EXAMINING THE RELATIONSHIP BETWEEN LEADERSHIP, FACILITATION, AND SHORT TERM SUSTAINABILITY OF A DEMENTIA-SPECIFIC TRAINING PROGRAM IN RURAL LONG-TERM CARE HOMES

A Thesis Submitted to the
College of Graduate and Postdoctoral Studies
In Partial Fulfillment of the Requirements
For the Degree of Doctor of Philosophy
In the Department of Medicine
University of Saskatchewan
Saskatoon

By

Tracy Danylyshen-Laycock

PERMISSION TO USE

In presenting this thesis/dissertation in partial fulfillment of the requirements for a Postgraduate degree from the University of Saskatchewan, I agree that the Libraries of this University may make it freely available for inspection. I further agree that permission for copying of this thesis/dissertation in any manner, in whole or in part, for scholarly purposes may be granted by the professor or professors who supervised my thesis/dissertation work or, in their absence, by the Head of the Department or the Dean of the College in which my thesis work was done. It is understood that any copying or publication or use of this thesis/dissertation or parts thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and to the University of Saskatchewan in any scholarly use which may be made of any material in my thesis/dissertation.

DISCLAIMER

Reference in this thesis/dissertation to any specific commercial products, process, or service by trade name, trademark, manufacturer, or otherwise, does not constitute or imply its endorsement, recommendation, or favoring by the University of Saskatchewan. The views and opinions of the author expressed herein do not state or reflect those of the University of Saskatchewan, and shall not be used for advertising or product endorsement purposes.

Requests for permission to copy or to make other uses of materials in this thesis/dissertation in whole or part should be addressed to:

Head of the Health Sciences Graduate Program
2D01 Health Sciences Building, 107 Wiggins Road
University of Saskatchewan
Saskatoon, Saskatchewan S7N 5E5 Canada

OR

Dean
College of Graduate and Postdoctoral Studies
University of Saskatchewan
116 Thorvaldson Building, 110 Science Place
Saskatoon, Saskatchewan S7N 5C9 Canada

ABSTRACT

In rural long-term care (LTC) homes staff have limited access to dementia specialty services and education to support them in caring for residents with dementia with responsive behaviours. A sustainable, in house, dementia-specific training program is one way to change practice to improve quality of care and keep staff and residents safe. However, the implementation and sustainability of new evidence and programs is complex and influenced by many elements. With a retrospective study (five homes), and a prospective study (two homes) over 15 months this dissertation examined how facilitation and leadership were related to short-term sustainability of a dementia-specific training program (Gentle Persuasive Approaches [GPA]) in rural LTC homes.

Based on the data from both studies (focus groups, semi-structured interviews, observations, and shadowing), a key finding of this research was that of variability across the seven homes in the sustainability of the GPA program, with a continuum of low, medium, and high sustainability. Both leadership and facilitation were important for sustainability but leadership was the key factor. The characteristics of the formal leaders determined the culture in the home, which influenced the degree of sustainability of the program. Paper 1 describes these leadership characteristics and their impact on the home's culture and GPA sustainability. Leaders who created a person-centred culture of care displayed interactive social and relationship-building skills that enabled staff to use the GPA program in their daily practice. Paper 2 examines the relationship between facilitation and sustainability. The GPA program was more likely to be sustained when there was more informal facilitation, GPA Coaches were credible, and there was someone in a formal facilitation role (e.g., clinical nurse leader) who coached and role modelled. Overall, this research found that the stronger the leadership, the more person-centred the culture of care is, which enables facilitators to help staff create change. This research addresses a gap in the area of implementation science related to leadership and facilitation in LTC settings and how these two concepts interact. This research will assist senior leadership in LTC homes to identify barriers to sustainability leading to better outcomes for residents, staff, and families.

ACKNOWLEDGEMENTS

I want to express my deepest gratitude to my supervisor, Dr. Debra Morgan, for her patience, time, and willingness to see me through this long academic journey. Words cannot begin to describe the number of times that she provided me with moral support and kind words that kept me going as I wrote my thesis. She helped me stand back up after cancer knocked me down and I will never forget how her quiet wisdom and kind heart made this all possible. I would also like to thank Dr. Norma Stewart for the time she spent with me as we discussed the methods and data analysis. Her sound advice and guidance gave me strength to continue on with my academic goals. I have been blessed with a committee of strong academic women who selflessly give their time and mentor up and coming master's and doctoral students. Thank you, Dr. Megan O'Connell, Dr. Donna Goodridge, and Dr. Shelley Kirychuk for being with me through this journey. I would like to thank CIHR and RaDAR for the funding that provided me with the opportunity to complete my PhD. I would like to thank the staff in the seven long-term care homes who participated in this research, without them, this would not have been possible. To Juanita Tremeer, the woman who accidently started me along this academic path, thank you. I had no idea that a request for a recommendation of a training program for long-term care homes would have turned into to a doctoral degree. Thank you to all of the staff at Seniors' Health and Continuing Care, especially Vanessa Ripley who supported my ability to research something that I value – person-centered dementia care.

DEDICATION

I would like to dedicate this thesis to my husband, Travis, and our two children, Grayson and Callam. They have stood beside me every step of the way, pushing me along in times when I did not think I would make it. Without their help I would not be where I am today. To my parents, Larry and Shirley, this is also dedicated to you because you raised me to never give up regardless of how hard life got. Thank you for teaching me this lesson. Finally, to my sisters, Tanya and Tamara, and all of my friends who were my cheerleaders over the last few years, I cannot begin to tell you how much your support means to me.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

AGE	Advanced Gerontological Education
CIHI	Canadian Institute for Health Information
CIHR	Canadian Institutes of Health Research
CNL	Clinical Nurse Leader
CNS	Clinical Nurse Specialist
DOC	Director of Care
GPA	Gentle Persuasive Approaches Program
GPA-R	Gentle Persuasive Approaches Recharge
i-PARIHS	Integrated Promoting Action on Research Implementation in Health Services Framework
LPN	Licensed Practical Nurse
LTC	Long-Term Care
NA	Nurse Aide
NP	Nurse Practitioner
PARIHS	Promoting Action on Research Implementation in Health Services Framework
PRN	As needed
RAI-MDS	Resident Assessment Instrument Minimum Data Set
RN	Registered Nurse
RPN	Registered Psychiatric Nurse
RT	Recreation Therapist

LIST OF APPENDICES

CHAPTER 1.0: BACKGROUND AND LITERATURE REVIEW

1.1 Rural Health Care

1.1.1 Seniors and Aging in Rural Areas

1.1.1.1 The rural aging population. The age demographics in Canada have changed significantly in the last 150 years. In 1871, the total number of individuals over the age of 65 made up only 3.6% of the total population, two in five individuals were 14 years or younger, and the average life expectancy was 40 years (Statistics Canada, 2017a). After World War II, Canada experienced an increase in the number of births between 1946 and 1965 (called the baby boom generation). Between 2011 and 2016, as the baby boomers approached 65, Canada experienced the largest increase (+20.0%) in the number of seniors aged 65 and older (Statistics Canada, 2017a). The percentage of individuals over the age of 65 (16.9%) is now larger than the percentage of children under the age of 15 (16.6%) within the Canadian population (Statistics Canada, 2017a). It is predicted that by the year 2031, 23% of Canadians will be over the age of 65 (Statistics Canada, 2017a). Essentially, the Canadian population is aging faster and is projected to do so because life expectancy (82 years) is increasing and the birth rate has been decreasing in generations since the baby boomers (Statistics Canada, 2017a).

According to Statistics Canada (2017a), there are significant differences across Canadian provinces regarding the proportion of the population who are seniors. Between 2011 and 2016, the Atlantic Provinces (Prince Edward Island, Newfoundland, Nova Scotia, and New Brunswick) experienced the highest increase in the proportion of seniors (between 19.4% and 19.9%) and the biggest decrease in the proportion of individuals between the ages of 15-64 in their population (Statistics Canada, 2017a). Similarly, Quebec, Ontario, and British Columbia had a higher proportion of seniors as compared to the Canadian average (18.3%, 16.7%, and 18.3%, respectively). The proportion of seniors 65 and older was lower than the national average in Manitoba (15.6 %), Saskatchewan (15.5%), Alberta (12.3%), the Yukon (11.9%), North West Territories (7.7%), and Nunavut (3.8%) (Statistics Canada, 2017a).

In Saskatchewan, there is a difference in the percentage of individuals over the age of 65 who live in rural versus urban areas. According to the 2016 Census, 87,940 people over the age

of 65 lived in rural and small population centres while 68,050 individuals lived in medium and large urban population centres (Statistics Canada, 2016). The number of seniors living in rural communities is expected to increase to 20.2% by the year 2025 (Moazzami, 2015). These seniors who live in rural communities have different challenges and barriers to overcome than seniors who live in urban settings. Individuals over the age of 65 living in rural areas often have limited access to emergency medical care, after hours care, and long-term care (LTC) beds within their community (Sapru, Cassidy, & Sibbald, 2014); fewer nurses (Bacsu et al., 2012; Pitblado et al., 2013; World Health Organization, 2010) and physicians (particularly as the area becomes more remote) (Meit et al., 2014).

1.1.1.2 Rural living and health. Some studies have found that the residents of rural communities have a higher frequency of physical illnesses (Haggarty, Ryan-Nicholls, & Jarva, 2010), poorer health (Bacsu et al., 2012), experience more chronic conditions (Baernholdt, Yan, Hinton, Rose, & Mattos, 2012), have increased death rates (for both men and women as communities become smaller and more isolated) (Meit et al., 2014), lower education levels (Haggarty et al., 2010; Moazzami, 2015), and lower incomes than people who live in urban centres (Baernholdt et al., 2012; Chipp et al., 2011; Haggarty et al., 2010; Moazzami, 2015). Additionally, rural seniors suffer from loneliness and being isolated (particularly elderly females) (Panazzola & Leipert, 2013) and experience a higher degree of stigma when accessing mental health services (Stewart, Jameson, & Curtin, 2015). Rural seniors have limited access to transportation to and from medical appointments (Bacsu et al., 2012), and longer distances to travel to specialist appointments (Skinner, Hanlon, & Halseth, 2012).

1.1.2 Health Care Providers and Clinical Practice in Rural Areas

1.1.2.1 Rural health care providers. Nurses in the Canadian health care system can be grouped into four different categories with some variation by province: Nurse Practitioners (NPs), Registered Nurses (RN), Licensed Practical Nurses (LPN), and Registered Psychiatric Nurses (RPN). According to MacLeod et al. (2017), in Canada, nurses who worked in rural and remote communities tended to be female. The largest percentage of NPs, LPNs, and RPNs ranged in ages between 45 and 54 years of age while the largest percentage of RNs are older (ages ranging from 55 to 64) (MacLeod et al., 2017). The most common levels of education for RNs, LPNs, and RPNs was a diploma. RNs were most frequently employed in hospitals (45.6%), while 37.1% of LPNs, and 22.2% of LPNs worked in LTC homes (MacLeod et al., 2017). In

Saskatchewan and Manitoba, 33.9% of nurses worked in a hospital and 27.8% worked in LTC homes. This was the highest percentage of nursing staff working in LTC homes across the country. Although the proportion of people who live in rural and remote communities in Canada is increasing, the number of RNs who work in these areas is declining due to an aging nursing population and a lower proportion of younger nurses working in rural and remote areas (MacLeod et al., 2017).

Clinicians who live in rural and remote communities struggle with different issues as compared to their urban colleagues. They work in environment where it is difficult to recruit and retain qualified health care staff (Forbes & Hawranik, 2012; World Health Organization, 2010). Rural practitioners contend with feeling isolated (deValpine, 2014; Hunt & Hunt, 2016) and often have to make greater efforts to be trusted and accepted within the community (Chipp et al., 2011). Rural health care practitioners may have to deal with unfavourable working conditions (Weinhold & Gurtner, 2014), dual relationships, limited resources (Chipp et al., 2011), a lack of specialists to consult with (Hunt & Hunt, 2016), higher patient numbers (Hunt & Hunt, 2016), and more hours of work than their urban counterparts (particularly nurse practitioners) (Spetz, Skillman, & Andrilla, 2017). In addition to these issues, nurses need to be multi-skilled when they work in rural and remote communities (Humphreys, Hegney, Lipscombe, Gregory, & Chater, 2002; Hunsberger, Baurmann, Blythe, & Crea, 2009; Hunt & Hunt, 2016; Stewart et al., 2005).

1.1.2.2 Training and education for rural health care providers. Individuals who work in rural settings have more difficulty than their urban counterparts in accessing continuing education and training (Hunsberger et al., 2009; Scott, 2000; Weinhold & Gurtner, 2014) due to a lack of continuing education opportunities (Hunt & Hunt, 2016), finances (Fitzgerald & Townsend, 2012), staffing shortages, lack of organizational support (Hunt & Hunt, 2016), competing demands (Hunt & Hunt, 2016) and time constraints (Fitzgerald & Townsend, 2012; Penz et al., 2007). If rural nurses do attempt to attend workshops or conferences, often they are required to do it on their own time, at their own expense and in locations that are often far away from their own communities (Fitzgerald & Townsend, 2012; Humphreys et al., 2002; Penz et al., 2007). Health care employees who were not physicians reported that they would prefer to have training sessions or continuing education within their own community (Dal Bello-Haas, Cammer, Morgan, Stewart, & Kosteniuk, 2014). Barriers to using current research in practice as

identified by rural nurses included: a lack of time to read research or implement new ideas (Hutchinson & Johnston, 2004), limited access to the internet (Winters et al., 2007), lack of support from management to use current research (Winters et al., 2007), lower levels of education (Kosteniuk, D'Arcy, Stewart, & Smith, 2006) and lack of computer, internet, and research skills (Kosteniuk et al., 2006; Winters et al., 2007).

1.1.2.3 Training for rural dementia care. According to researchers, staff who work in LTC homes often have little to no training in the care of the elderly (Eaton, 2003; Hudson, 2003; LaMascus, Bernard, Barry, Salerno, & Weiss, 2005). It is imperative that staff who work in rural areas receive the appropriate training in order to work with the people diagnosed with dementia (Daniels, VanLeit, Skipper, Sanders, & Rhyne, 2007; Morgan, Innes, & Kosteniuk, 2011; Moyle, Hsu, & Vernooij-Dassen, 2010). Given that age is the main risk factor for cognitive decline (Lipnicki et al., 2013) there are likely many people living with dementia in rural areas. At the same time, rural communities have fewer dementia specialists and staff with expertise in dementia care (Morgan et al., 2011). Health care providers who work with residents with dementia have limited access to continuing education, making it difficult to receive the training that they require to work in rural settings, include LTC homes. It is therefore important to implement and sustain training programs in these areas to help staff care for residents with dementia.

A sustainable training program is one way to change the culture and assist staff in managing behaviours from residents with dementia living in LTC homes (Boscart, 2016; Eaton, 2003; Spector, Revolta, & Orrell, 2016). It builds the skill set of the care team who work with the residents living in the rural care homes (Grand, Caspar, & Macdonald, 2011), decreases staff burnout (Morgan et al., 2011; Spector et al., 2016), and builds capacity as opposed to being dependent on external support for managing behaviours. Rural care homes tend to be smaller and have limited access to dementia specialist services and resources who can provide support to staff on an ongoing basis (Morgan et al., 2011). Staff need the opportunity to develop these specialized skills because they provide direct care to residents with cognitive impairments. The health care system must do this by finding creative and flexible ways to build capacity within the rural communities as opposed to sending staff away for training (Dal Bello-Haas et al., 2014; Haggarty et al., 2010).

1.2 Dementia Care in Long-Term Care Homes

1.2.1 Philosophy of Care, Dementia, and Responsive Behaviours in Residents Residing in Long-Term Care Homes

1.2.1.1 Dementia and dementia care in Canada. There are currently 564,000 people in Canada living with dementia, and an additional 25,000 individuals will be diagnosed each year (Alzheimer Society of Canada, 2018a). It is expected that the number of people living with dementia will almost double over the next 15 years (Alzheimer Society of Canada, 2018a). As our society witnesses an increase in the number of people with dementia, the cost of providing care to these individuals will also increase. In 2016, the cost to both the family and the Canadian medical system to provide care for people living with dementia was approximately 10.4 billion dollars (Alzheimer Society of Canada, 2018a). By the year 2031, this number is expected to rise as high as 16.6 billion dollars (Alzheimer Society of Canada, 2018b). The majority of the medical costs are directly related to LTC homes and home care services (Alzheimer Society of Canada, 2016).

In 2017-2018, 1,360 LTC homes reported their RAI-MDS 2.0 (Resident Assessment Instrument Minimum Data Set) data to the Canadian Institute for Health Information (CIHI). A total of 207,424 people across Canada lived in LTC during this reporting period and 12,436 were from Saskatchewan. Overall, the average age of residents living in the LTC homes who report to CIHI was 84 years and 65.4% were female. In Canada, 62% of residents in LTC homes had a diagnosis of dementia. Saskatchewan LTC home residents were mainly female (61.9%) with an average age of 83 years. The percentage of residents living in Saskatchewan's LTC homes who had a reported diagnosis of dementia was 48.6%. By the year 2038, the demand for LTC beds will increase tenfold, creating a shortfall of 157,000 beds (Alzheimer Society of Canada, 2010). As a result, individuals with severe dementia requiring higher levels of care will have to rely on community based and informal care supports (Alzheimer Society of Canada, 2010).

1.2.1.2 Philosophy of care for residents in long-term care homes. The health care system in the western world has undergone a significant transformation since the 17th and 18th centuries. At that time, criminals, the poor, and people with mental or physical disabilities were considered to be "crazy" or "immoral" and were locked away in institutions with others displaying similar behaviours. These individuals were chained to the walls and often tortured as opposed to being treated. Medical professionals at the turn of the 19th century, began to see that

the treatment of individuals in these institutions was barbaric and cruel. As a result, advocates began to protest and demand better conditions for those with mental and physical disabilities. Still, little was done to explore the underlying causes of why people were depressed, forgetful, violent, or unable to work. It was not until the early part of the 20th century that medical professionals discovered that there could be an underlying physical reason for mental health illnesses instead of "low moral character" as previously thought.

Although the term dementia was mentioned by Greek scholars, it did not receive much attention in the psychiatric community until almost the end of the 20th century (aside from the discovery of Alzheimer's disease in 1906; Gilmour & Brannelly, 2010). Individuals with dementia were housed in the same asylums as other individuals with mental and physical disabilities and they often received care that was not appropriate (Kitwood, 1997). After the asylums closed, people with dementia were treated in the psychiatric and medical wards of hospitals (Gilmour & Brannelly, 2010). During this time, the focus on the physiological causes of dementia created a culture of the doctor as the expert whereby the lived experience of the person diagnosed with dementia was ignored (Clarke, Wolverson, & Moniz-Cook, 2016; Gilmour & Brannelly, 2010). Within this paradigm, advancement in dementia research focused on technological advancements and finding a cure for dementia (Clarke et al., 2016; Rahman, 2015).

The view of dementia as a medical disorder created a world where individuals with dementia are believed to be "suffering" from the symptoms, and their journey is defined by stages that lead to living a life that has no value, followed by death (Clarke et al., 2016). Individuals with dementia are often viewed as having a poorer quality of life and are faced with being stigmatized, labelled, and disenfranchised within our society (Brooker & Latham, 2016; Rahman, 2015). Although it is changing, labelling and stigmatizing residents with dementia has been part of the underlying current within health care settings under the institutional model paradigm. In these LTC homes, residents with dementia are sometimes referred to by their diagnosis, illness, or symptoms (Duffy, 2016; Fox, 2007). They tend to be viewed as failing, sick, needy, or helpless (Duffy, 2016; Fox, 2007; Norton & Shields, 2006). Staff in care homes may believe that because a person living in a care home is older, sicker, and frailer, they are no longer able to live the life that they used to lead. As a result of this attitude, care staff may fail to take previous lifestyle choices into consideration when providing care (Harnett & Jönson, 2017).

1.2.1.3 Institutional model of care and language use. Within a home that follows an institutional model of care, interactions between the staff and residents are underpinned by the notion that residents with dementia are no longer able to interact with others in what is viewed as a "meaningful" way. Kitwood (1997) identified interactions called malignant social psychology, including: treachery, disempowerment, infantilization, intimidation, labelling, stigmatization, outpacing, invalidation, banishment, objectification, ignoring, imposition, withholding, accusation, disruption, mockery, and disparagement. He suggested that "the word malignant signifies something very harmful, symptomatic of a care environment that is deeply damaging to personhood" (Kitwood, 1997, p. 46). He identified that when these interactions occur, staff members are not being intentional about them, but instead they occur as part of the cultural fabric in LTC. Several of the malignant interactions identified by Kitwood (1997) focus on the use of language when caring for someone with dementia.

Language and discourse are powerful tools (which often go unnoticed) in shaping the world in which people with dementia live (Brooker & Latham, 2016). Within the institutionalized notion of dementia care, negative language reinforces the stereotypes of people with dementia as being helpless, frail, useless, or having no quality of life after the dementia diagnosis. Inappropriate terminology comparing the dementia journey to an unsuccessful military battle is often used. For example, people with dementia are "fighting a good fight" or medical practitioners are "waging a war" to cure this disorder. These negative terms undermine the value of the person as a human being and impact their sense of self (Clarke et al., 2016). When staff work in a particular setting, they may learn to use the language that is common within that culture (Crowe, 2005; McCloskey, 2008). For example, LTC homes may be referred to as institutions or facilities (Schoeneman, 2010), and residents may be referred to as "feeders," "wanderers," "walkers," or "patients" (Fox, 2007; Frampton et al., 2010; Schoeneman, 2010). Residents may wear bibs, diapers, gowns, or pull-ups and need to be "put down," "changed," "walked," or "toileted." Behaviours may be referred to as "challenging" or "agitated" and residents described as refusing to "comply with care" (Frampton et al., 2010; Schoeneman, 2010). These labels diminish quality of life, create stereotypes, and paint people in LTC who are seeking health care supports as outliers within the community (Duffy, 2016).

1.2.1.4 Person-centered care. Personhood and person-centered care are terms coined by Kitwood (1997) to describe a new culture of care for individuals with dementia. Personhood is

the view that people with dementia have worth and are able to connect and maintain deep relationships with those around them (Kitwood, 1997). Person-centered care focuses on the how a person with dementia can live a life that is meaningful and full of worth (Kitwood, 1997). Kitwood focused his research towards developing the philosophy of person-centered care by identifying the types of interactions that promote positive relationships between care givers and individuals with dementia. Recognition, negotiation, collaboration, play, timalation (i.e., an interaction based on sensations), celebration, relaxation, validation, holding, and facilitation are the ten types of interactions that support person-centered care (Kitwood, 1997). Many care homes are on their way to creating a culture that is person-centered, respectful, and caring. These homes are working very hard at changing the way that residents are cared for and treated. This includes using language that reflects person-centered care.

1.2.1.5 A note on terminology. Within the current research, the terms resident, LTC, care home, and care community will be used to reflect a person-centered care approach. Additionally, within a person-centered model, when residents are expressing or displaying emotion, these behaviours are viewed as an expression of a need. Residents are viewed as responding to something in their environment that is not quite right (Talerico & Evan, 2000). When behaviours are reframed as responsive, it directs staff to search for the reason behind the behaviour and provide care in a way that is respectful and person-centered. The term "responsive behaviours" is in alignment with the view that these behaviours may be an expression of an unmet need or an indication of a problem in the environment for someone with dementia (Talerico & Evan, 2000). The term physically responsive behaviours will be used throughout this manuscript in place of "violence," "aggression," "agitation," "assaults," and "physical abuse." The term verbally responsive behaviours will be used in place of "verbal abuse," "verbal aggression," or "emotional abuse."

1.2.1.6 Dementia and responsive behaviours. People who have been diagnosed with dementia face changes in their physical well-being, with many experiencing a change in their personality and behaviour (Alzheimer Society of Canada, 2017a). Commonly reported responsive behavioural symptoms displayed by someone with dementia include verbal and physical responsive behaviours (Davison et al., 2017; Zwijsen et al., 2014), depression (Cerejeira, Lagarto, Mukaetova-Ladinska, Massano, & Agosta, 2012), apathy (Cerejeira et al., 2012), irritability (Cerejeira et al., 2012), anxiety (Cerejeira et al., 2012; Selbæk, Engedal, &

Bergh, 2013), resistance to care, and inappropriate social and sexual behaviours (Davison et al., 2017).

The proportion of residents with responsive behaviours varies considerably in the literature, likely due to differences in the population studied, measures used, and the fact that many responsive behaviours go unreported by staff (Scott, Ryan, James, & Mitchell, 2011a) . Staff members may be too afraid to report incidents for fear of being blamed or being fired (Scott, Ryan, James, & Mitchell, 2011b). Kolanowski and Garr (1999) reported that 44% of residents with dementia display responsive behaviours, while Brodaty et al., (2001) suggested that 82% of residents show signs of physical responsive behaviours. According to Isaksson, Graneheim, Åström, and Karlsson (2011), 31.7% of residents showed signs of physically responsive behaviours during a 7 day period. In a systematic review, Selbæk et al. (2013), found that up to 80% of residents living in care homes displayed some type of physically or verbally responsive behaviours.

Nursing aides and nurses are the most frequent recipients of the responsive behaviours (Edward, Ousey, Warelow, & Lui, 2014; Gates, Fitzwater, & Succop, 2003; Goodridge, Johnston, & Thomson, 1996; Graydon, Kasta, & Khan, 1994). Some staff may experience responsive behaviours on a daily basis (Banerjee et al., 2008). In a systematic review that looked at occupational anxiety related to physically responsive behaviours in nurses, Edward et al. (2014) found that the rates of physically responsive behaviour was higher in mental health institutions, LTC homes, and emergency rooms. Verbally responsive behaviours were more likely to be directed at general nurses. Boström, Squires, Mitchell, Sales, and Estabrooks (2012) concluded that staff in dementia care areas experienced more acts of physical and verbally responsive behaviours than staff in hospitals. Daly, Banerjee, Armstrong, Armstrong, and Szebehely (2011) found that four out of ten workers experienced responsive behaviours almost daily and two out of ten staff members experienced physically responsive behaviours almost weekly. Similarly, Estabrooks, Squires, Carleton, Cummings, & Norton (2015) reported that care aides experienced approximately three different responsive behaviours over their last five shifts. According to Boström et al. (2012), two-thirds of staff (licenced practical nurses and care aides) in four dementia care areas reported that they experienced a physical or verbal responsive behaviour in a one month period. The most common types of responsive behaviour that staff experienced were physical (50% of staff) and verbal behaviours (48% of staff).

Several studies have reported that the majority of responsive behaviours toward nursing aides occur in the resident's room during care or intimate procedures (i.e., toileting, transferring, or dressing; Gates et al., 2003; Gates, Fitzwater, & Succop, 2005; Morgan et al., 2007; Scott et al., 2011a). The most common responsive behaviors experienced by nursing aides are slapping, squeezing, or punching (Cassidy et al., 2005; Gates, Fitzwater, & Deets, 2005; Morgan et al., 2007). The nursing aides often normalize and expect "violence" to be "part of their job" (Daly et al., 2011, p. 281). Similar to nursing aides, nurses also normalize their experiences with residents with responsive behaviours (Edward et al., 2014). Nurses who experience responsive behaviours often do not report the incidents because of poor management response and support, and ambiguous workplace policies related to responsive behaviours (Edward et al., 2014).

1.2.1.7 Impact of responsive behaviours on LTC staff. When LTC staff are exposed to responsive behaviours (either witnessing the event, or being injured by a resident) they may experience long lasting physical, emotional, and psychological consequences (Edward et al., 2014; Isaksson et al., 2011; Scott et al., 2011b). These individuals may doubt their career choice (Needham et al., 2005), become distressed (Zwijsen et al., 2014), suffer from psychological trauma (Scott et al., 2011b; Snellgrove, Beck, Green, & McSweeney, 2015) and burnout (Estabrooks et al., 2015), and withdraw emotionally and physically from the residents that they care for (Scott et al., 2011a, 2011b). They may also experience headaches, insomnia, and other physical illnesses (Wang, Hayes, & O'brien-Pallas, 2008). Scott et al. (2011a; 2011b) noted that when staff do not understand the triggers behind the behaviour (i.e., believing the behaviour was intentional), in addition to feeling emotionally and physically exhausted, there is potential for staff to abuse the residents that they are caring for. On a systems level, when staff are physically and emotionally burnt out, there may be an increase in staff turnover and days off, a decrease in work productivity, and an unstable work environment (Fernandes et al., 1999; Gerberich et al., 2004).

1.2.1.8 Training staff to manage responsive behaviours. In response to the number of staff being injured in workplaces across Canada, many Occupational Health and Safety Committees have called for the implementation of programming that will help staff in recognizing and mitigating the risk of being hurt in the work place. For example, Saskatchewan Occupational Health and Safety Regulations (1996) mandate that an employer must provide "violence awareness" training to employees if they are employed in a work place where there is a

potential threat of being injured. Specifically, this program must provide employees with the ability to "recognize potentially violent situations, procedures, work practices, administrative arrangements and engineering controls that have been developed to minimize or eliminate the risk to workers" (Saskatchewan Occupational Health and Safety Regulations, 1996, p.26).

In addition to Occupational Health and Safety Committees, staff, administrators, and researchers have recommended and found evidence to support that training programs specifically designed to manage responsive behaviours in care homes reduce responsive behaviours (Alzheimer Society of Canada, 2010; Aylward, Stolee, Keat, & Johncox, 2003; Morgan et al., 2007; Morgan et al., 2005; Scott et al., 2011a, 2011b; Snellgrove et al., 2015; Spector, Orrell, & Goyder, 2013). Care staff reported that they feel that they do not have an appropriate understanding of dementia (Jones, Moyle, & Stockwell-Smith, 2013), nor do they feel that they have the skills to deal with responsive behaviours in residents with dementia (Gates et al., 2005). The nursing aides, who have the most contact with residents, are being hurt (Hoskins, 2006). Due to time constraints (Brazil, Royle, Montemuro, Blythe, & Church, 2004), or budgetary restrictions (Aylward et al., 2003), many care homes do not provide adequate behavioural management training to their staff. If training is offered, it may not be adequate in terms of course content and length (Cassidy et al., 2005), or not designed for staff who work with residents with dementia (Lennox, 2004).

1.2.2 Types and Elements of a Dementia-Specific Training Program in Managing Responsive Behaviours in Long-Term Care Homes

1.2.2.1 Types of dementia-specific training programs across Canada. Many behavioural management programs that have been implemented in LTC homes across Canada were created for staff in the correctional system, acute care, or mental health settings (Schindel Martin & Dupuis, 2005). A survey of provincial Alzheimer's Societies, WorkSafe organizations, and LTC governmental agencies (names of these organizations vary across the country) completed by the writer in 2017 indicated that dementia training for LTC staff varied across the provinces and territories. In British Columbia, Alberta, and New Brunswick, some homes used either (a) a program called Non-Violent Crisis Intervention (NVCI), (b) modified NVCI for LTC homes, or 3) supplemented the NVCI with the PIECES program. The PIECES program was designed to assist professional staff, care teams, and organizations who provide care to individuals diagnosed with dementia to help assess and create resident-specific care plans in

order to effectively manage responsive behaviours (PIECES Program, 2013). The P-I-E stand for the resident's physical, intellectual, and emotional health, the C represents capacities, and the E-S stands for the environment and the social self of the resident. Other LTC homes in British Columbia, Alberta, and New Brunswick have trained staff in the Gentle Persuasive Approaches (GPA) program (some more sparingly than others). Manitoba has trained staff in a provincially designed program in conjunction with the PIECES program. In Saskatchewan, Ontario, Prince Edward Island, Nova Scotia, and Newfoundland, the Gentle Persuasive Approaches Program (often in tandem with the PIECES Program or another in-house training program) has been selected as the training program for LTC in most health regions. Other programs that are being implemented (albeit inconsistently across the country) include the Maria Montessori training program and the U-FIRST program through the Alzheimer Society of Canada. The U-FIRST program was created by the Alzheimer Society of Canada for LTC home staff members who provide care to individuals with dementia. The U stands for understanding the reasons for responsive behaviours and F reminds staff to flag the changes in the person that they are caring for. I-R-S stands for interacting in new ways, reflecting/reporting behaviours, and supporting the person with dementia, while T reminds staff that they are important members of an entire health care team.

1.2.2.2 Elements of a dementia-specific training program for staff in LTC homes. In order to prevent sick leave, injuries, and employee turn-over, the health care system must provide support and training that meets the needs of staff who work in care homes. In 2009, the researcher was asked by her employer to conduct a literature review to identify course components that were necessary in a dementia-specific training program. Although not a formal systematic review, common elements identified as fundamental to a training program included: understanding the reasons for responsive behaviours; recognizing a behavioural escalation; learning communication skills to calm a resident with responsive behaviours; identifying the differences between institutional care and person-centered care philosophies; developing de-briefing, de-escalation, and appropriate follow up policies and procedures for when an interaction with a resident with responsive behaviours has occurred; understanding behavioural management principles; learning safe and respectful manoeuvres when an unsafe situation occurs; and a program evaluation component.

There are many educational programs available to train staff in managing responsive behaviours and it is possible that some were missed in the review. However, after examining the curricula of 10 behavioural management programs (GPA, Professional Assault Response Training, PIECES, Prevention and Management of Aggressive Behaviours, Geri-Care, Non-Violent Crisis Intervention Program, Therapeutic Options, MANDT, Critical Incident: Positive Outcome, Crisis Aggression Limitation Management), Danylyshen-Laycock (2009) concluded that the GPA program met all of the criteria recommended in the literature. As a result of this review the GPA program was selected to be implemented into the 30 LTC homes in a large health region on the Canadian Prairies.

1.3 The Gentle Persuasive Approaches Program

1.3.1 The GPA program

The GPA program is an evidence-based program that was originally designed for staff in LTC homes for the purpose of teaching staff to identify and manage responsive behaviours displayed by residents with dementia. Currently, other areas of the health care system across Canada (e.g., acute care sites, nursing education programs, and Occupational Health and Safety Offices) are training staff members and implementing the program into their organizations. The program was first created in December 2003 by a steering team consisting of professionals from the fields of nursing, education, and mental health in Ontario, Canada. The overarching goal of the GPA program is teaching staff "using a person-centered, compassionate, and gentle persuasive approach, to respond respectfully to behaviours associated with dementia" (Advanced Gerontological Education, 2017b). Four objectives help staff in reaching the program goal. These include: (a) recognizing that a person with dementia is unique and is still able to interact with the environment around them, (b) explaining how the brain changes as a result of dementia and can lead to responsive behaviours, (c) learning to use emotional, environmental, and communication skills to minimize or de-escalate responsive behaviours, and (d) teaching self-protection strategies to use when a situation is unsafe (Advanced Gerontological Education, 2017b). At present, over 288,000 individuals in 1,700 organizations across Canada have taken the GPA 7.5 hour training course.

1.3.1.1 Revisions of the GPA program. Since the creation of the GPA Program, the curriculum has gone through three revisions. In 2015, the third edition was introduced (Advanced Gerontological Education, 2015). The following changes were made to the GPA

Program: the curriculum was reorganized to enhance flow; information in the course was based on current in-depth literature reviews; the material presented on delirium was expanded; self-reflection and module review questions were included at the end of each module; white board animation, updated photos and video clips were added; and practice tips, examples, and core competencies were provided. The language within the curriculum and teaching materials were changed to reflect a person-centered care approach to dementia (i.e., changing the language from "responding to persons with challenging behaviours" to "supporting persons with responsive behaviours").

1.3.1.2 GPA 3rd edition curriculum. The GPA course is based on best practice guidelines for dementia care and the curriculum development and presentation is rooted in adult learning principles, the Promoting Action on Research Implementation in Health Services (PARIHS) framework (Rycroft-Malone, 2004), and the Bandura Theory of Self Efficacy (Bandura, 1986). Course content includes video clips, white board animation, resident stories, role plays, and self-reflection exercises. The GPA program consists of four modules delivered over 7.5 hours (Advanced Gerontological Education, 2015). Module 1 focuses on the concept of person-centered care and the view that there is meaning behind the behaviours displayed by residents with dementia. Module 2 highlights how the brain is affected by the dementia process. It explains how the eight A's of dementia (anosognosia, amnesia, aphasia, apraxia, agnosia, altered perception, attentional deficits, apathy) change how a resident thinks, acts, or responds to their environment. This module provides staff with clinical interventions to support residents when the responsive behaviours are present.

Module 3 teaches staff how to effectively communicate with a resident with dementia in a way that will not increase responsive behaviours. It gives staff the skills to be able to identify escalating behaviours and intervene early. The GPA program re-enforces throughout the first three modules that staff should rely on their communication and interpersonal skills before they attempt to physically touch a resident who is upset. In Module 4, staff learn the skills to physically protect themselves in ways that are respectful and safe for the residents. They learn ways to reduce the risks of being hurt (or hurting a resident) and how to use the respectful escort techniques (in teams and alone) to manage catastrophic events (Advanced Gerontological Education, 2015).

1.3.1.3 GPA teaching models. For the first and second editions of the GPA program, the "train the trainer" teaching method was used in which two staff members per LTC home attended a two-day GPA training course taught by GPA Master Coaches to become certified as Coaches. The Coaches would then teach a 7.5 hour course in their own LTC homes. Two GPA Coaches were required to teach the course to a maximum of 12 participants. The teaching model changed with the third edition of the GPA program (Advanced Gerontological Education, 2017a). GPA Coaches are now able to teach the 7.5 hour course on their own in their LTC home, as long as the ratio in a single class does not exceed one GPA Coach to ten staff members. This is to ensure that all participants are competent in the program upon completion. A maximum of 20 participants and two Coaches are allowed in one training course. In order for current GPA Coaches to receive certification as Coaches for the third edition, they are required to watch a 20 minute video on the changes to the curriculum for each module. They are then required to complete a tutorial and pass a short quiz before they are allowed to teach and have access to current teaching material.

GPA Coaches are not trained as formal facilitators, but they may play an important role in the implementation and sustainability of the GPA program. The Advanced Gerontological Education (AGE) is the organization that oversees the development and delivery of the GPA course across Canada. With the third edition of the program, AGE has recommended but has not mandated the GPA Certified Coach In-House Champion Model for larger organizations. Specifically, the LTC home or hospital may hire an in-house GPA Coach who is able to work with staff in real time to teach the 7.5 hour GPA course and the recertification course as needed (Advanced Gerontological Education, 2017b). AGE is currently working with curriculum developers, LTC staff, and other professionals on ways to sustain GPA in smaller or rural areas.

1.3.1.4 GPA coach selection process. At the time of implementation of the GPA program in a large health region on the Canadian Prairies in 2009, GPA Coaches were selected by the Managers or Directors of Care within the LTC homes. Many of the Coaches who received the GPA Certified Coach training were nursing aides, Registered Nurses, Licensed Practical Nurses, Recreation Therapists, or Clinical Nurse Leaders. A few LTC homes sent dietary, or administrative staff to the GPA Coach training. Many of the earlier GPA Coaches did not have previous teaching or facilitation experience but were selected by their supervisors because these individuals exhibited person-centered care techniques when working with residents with

dementia. In 2015, AGE changed their process on who can become certified GPA Coaches. They requested that individuals applying to take the two-day Coach Certification training course had previous experience in dementia care, experience in teaching, already work closely with the staff who will be taking the GPA training course, and had previous exposure to the GPA training course. Proof of this experience and a letter indicating support from the employer had to be submitted to AGE before participants were allowed to take the two-day GPA Coach Certification course.

1.3.1.5 GPA coach agreement. With the third edition, several additions were made to the GPA Coaching agreement (Advanced Gerontological Education, 2017a). After GPA Coaches take the initial two-day training course, they are responsible for teaching 40 hours of the GPA Course and recertification course over two years. This teaching period may include up to ten hours of Continuing Education. According to the Coaches Agreement, Continuing Education may consist of activities grouped under two categories: 1) GPA-Related Facilitation, and 2) Other Education. Activities that fall under the GPA-Related Facilitation category include case-based discussion that may include identifying strategies, skills and solutions to supporting individuals with responsive behaviours, and coordination of Behavioural Rounds or Responsive Behaviour Team Facilitation. Examples of activities that are included in the Other Education category include: PIECES training, Montessori Method training, Geriatric Mental Health Days, or U-First training. GPA Coaches must also pay a bi-annual fee of $100. Renewal fees are used in part to ensure that GPA Coach certification records are accurate and up to date. This ensures that all GPA Coaches are meeting the criteria set out in the Coaches Agreement.

1.3.1.6 GPA online learning. An online GPA course has been developed for individuals who are (a) currently enrolled in a Geriatric Certificate program or an accredited health care program, (b) employed in an area in which they work with individuals with dementia, (c) live in an area where there are no certified GPA Coaches; or (d) looking to work in a setting where the GPA 7.5 hour training course is a prerequisite (Advanced Gerontological Education, 2017c). The online course is an adapted version of the 7.5 hour GPA program and has been designed so that participants may learn in their own environment at their own pace. The training program takes approximately 2-3 hours to complete, must be completed within four weeks of the start date and is not intended to replace the one-day GPA course. The manual can be downloaded prior to the start of the online course and the students can use it to follow along with the tutorials. The e-

learning course is comprised of video tutorials, and students complete online activities to strengthen their learning. The cost to register for the online learning course is $90.00 for a single participant but prices decrease if larger groups register together.

1.3.1.7 GPA recertification process. The curriculum developers have created an evidence-based yearly GPA recertification process entitled "GPA-Recharged" (GPA-R) (Advanced Gerontological Education, 2017d). The recertification is based on the core components of the GPA Program and is taught by the GPA Coaches. The purpose of the recertification is to (a) provide staff the opportunity to refresh and reinforce their GPA skills, and (b) allow staff to participate in smaller group discussions to apply the skills they have learned to specific scenarios since the GPA initial training. The GPA-R is taught in two sequential one-hour sessions (either the same day or one week apart) in groups of six to eight (maximum 12) participants. The first session involves information from Modules 1 and 2 and the second session discusses material from Modules 3 and 4. AGE recommends that individuals participate in the GPA Recharged program for the first two years post initial training. At year three, it is recommended that the participants re-take the 7.5 hour GPA training course (Advanced Gerontological Education, 2017e).

1.3.2 Fidelity of the GPA Program

Century, Rudnick, and Freeman (2010) define fidelity of implementation as "the extent to which the critical components of an intended program are present when the program is enacted" (p. 202). Core elements are the components of a program or intervention that are considered important or essential to the success of a program (Allen, Linnan, & Emmons, 2012; Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005). In contrast, "adaptive" elements are those that may be changed to fit different local contexts without violating program fidelity and effectiveness (Lee, Altschul, & Mowbray, 2008). While maximizing fidelity has been viewed as key to achieving expected outcomes, there is a growing recognition of the need to balance program fidelity and adaptation to ensure fit with local practice settings (Durlak & DuPre, 2008; Lee et al., 2008; Stirman et al., 2012). Several researchers suggest that the debate between fidelity and adaption should be viewed as not in terms of "one or the other" but creating the right mix of fidelity and adaptation (Berkel, Mauricio, Schoenfelder, & Sandler, 2011; Durlak & DuPre, 2008; Scheirer & Dearing, 2011). When programs or interventions have been adapted, this can

improve the "fit" of the intervention with the context and program recipients, leading to improved program sustainability (Allen et al., 2012; Berkel et al., 2011).

The GPA course was implemented in a large health region on the Canadian Prairies with fidelity. Although not the main focus of the current research, fidelity is a relevant concept because a lack of fidelity (i.e., failure to effectively implement core program components) could impact sustainability. This research focused on the sustainability of the GPA program after initial training thus it is important to consider whether there was fidelity to the original intervention. The GPA program in the seven LTC homes included in this study is a highly structured program that helps to ensure adherence to the training protocol. It was taught by GPA Coaches who attended a two-day program that was delivered by experienced facilitators (Master GPA Coaches). All staff members received the training (which included the core elements of the program) within the homes. All staff received the same training manual and the course was taught the same way (in a 7.5 hour training session) in all of the homes using the same teaching materials (power point presentation and video clips). Master Coaches attended several of the training sessions during program training within all seven homes to ensure that the Coaches were teaching the content in the way that it was designed and to ensure the quality of the teaching sessions. Given that the GPA program was taught in a standardized way according to the original program design across the area involved in this research project, the differences in sustainability within the seven LTC homes in this research project are unlikely to be due to variation in program delivery.

1.3.3 Evaluation of the GPA Program in Various Health Care Settings

1.3.3.1 Initial GPA evaluation in LTC homes. The Gentle Persuasive Approaches program was evaluated by the program developers in 2004 in seven care homes in seven health regions in Ontario, Canada (Schindel Martin & Dupuis, 2005). Qualitative and quantitative strategies were used to collect evaluation data. Survey questionnaires (e.g., Perceived Competency Scale, Behavioural Agitation Attitudes Scale, and Values Clarification Scale) were developed that assessed participants' perceived competency level, attitudes, and beliefs towards working with residents who display responsive behaviours and their overall satisfaction with the curriculum (Schindel Martin & Dupuis, 2005). The survey was conducted three times during the evaluation period: prior to the training, immediately after training, and six weeks after completion of the training. The qualitative methods that were used included a pre- and post-

training focus group, interviews with key informants after the training, and open-ended interviews with the curriculum participants and Master Trainers six weeks after training. A total of 205 people participated in the quantitative evaluation of the GPA program. Of these 205 people, 188 (92%) completed the pre-training and immediate post-training measures and 75 individuals completed the pre-training, immediate post-training, and six-week evaluation questionnaires.

According to Schindel Martin and Dupuis (2005), the results of the evaluation revealed that participants were satisfied with the GPA curriculum and the length of the course. Participants indicated that the GPA program was well organized and provided new information that would be helpful in daily practice. Paired *t*-tests were used to determine whether there was a change in staff perceived competency, attitudes, and values as a result of participating in the GPA program. The analysis showed that there was an increase in perceived competency immediately after staff attended the GPA training. Staff reported that they were able to identify the reasons for the behaviour, felt more confident in the way that they communicated with residents with dementia, and were able to identify respectful and person-centered strategies that they could use to de-escalate a situation if required. Results of the perceived competency survey were sustained six weeks after training (Schindel Martin & Dupuis, 2005). Staff reported that they maintained the ability to understand the reasons for responsive behaviours and were able to respond appropriately to residents when needed. Although the initial improvement demonstrated in overall summary scores for the perceived attitudes and values scales were not sustained at six weeks post-training, improvements were sustained for several individual items, including staff agreement with "What is wrong is not the emotional expression, only its public display."

1.3.3.2 Evaluation of the GPA program in acute care settings. Speziale, Black, Coatsworth-Puspoky, Ross, and O'Regan (2009) completed an evaluation of the GPA program within an inpatient psychogeriatric unit of 108 beds in Ontario, Canada. They measured staff satisfaction with the GPA curriculum prior to training, immediately after training, and three months post-training. Occupational Health and Safety reports and the number of physically responsive behaviours recorded in the risk management computer system were examined prior to the implementation of the GPA program and three months after the program had been implemented. Results demonstrated a statistically significant improvement in staff confidence levels in managing responsive behaviours. There was an almost 50% decrease in physically

responsive events and there was no change in the number of occupational injury rates (Speziale et al., 2009). Speziale et al. concluded that the GPA program is not only effective for staff working with residents with dementia, but the curriculum could also be used by staff who work with residents with other diagnoses.

In 2009, Pizzacalla et al. (2015) evaluated the implementation of the GPA program on a 32 bed orthopaedic nursing unit where many of the patients had dementia and delirium. The purpose of their research was to examine how unit-based nursing leaders implemented, evaluated, and used outcomes from the GPA program, with the aim of gaining senior leadership support for the implementation of the program across the hospital. The researchers measured participant self-efficacy using a ten-item, seven-point Likert scale entitled the *Self-perceived Behavioural Management Self-Efficacy Profile* prior to training and immediately after training (Pizzacalla et al., 2015). This survey was intended to measure participants' perception of their abilities to use the GPA core competencies effectively. Seventy-two participants completed the survey. According to Pizzacalla et al., results showed statistically significant improvement on all scores on the survey immediately after training. In addition to the survey, the nursing leadership team observed several changes in behaviour from their staff weeks after training. They noticed staff admitting patients with responsive behaviours in rooms closer to the nursing station and staff discussing their successes with co-workers related to using the GPA skills (e.g. using validation and redirection when patients had a delirium). Staff members also reported to nursing leadership that they felt there was a decrease in the number of Code Whites (violent scenario) being called, as well as a reduction in the number of restraints being used (Pizzacalla et al., 2015). The success of the GPA program on this orthopaedic unit inspired three other units (medical and rehabilitation) in the same hospital to offer GPA training to their staff.

As a result of the success of the GPA program in the orthopaedic unit as described above by Pizzacalla et al. (2015), further funding was secured by Schindel Martin et al. (2016) to examine the impact of the GPA program on the ability of staff to manage responsive behaviours related to dementia and delirium in a multi-site acute care hospital in Ontario, Canada. Schindel Martin et al. were interested in examining whether or not the GPA program changed the self-efficacy of acute care staff as compared to a wait-listed group who had no exposure to the GPA program when managing responsive behaviours displayed by residents with dementia. Self-efficacy was measured using the same tool (the *Self-Perceived Behavioural Management Self-*

Efficacy Profile) as in the study by Pizzacalla et al. Focus groups were held to gain an understanding of staff members' experiences in using the GPA program in their daily practice. The intervention group and the wait-listed groups participated in a focus group at baseline and eight weeks post-GPA training. In addition, the intervention group participated in a focus group immediately after training.

Schindel Martin et al. (2016) hypothesized that (a) immediately after the GPA program was taught, staff members would have higher levels of self-efficacy when managing behaviours using a person-centered approach, (b) immediate post-interventions scores of self-efficacy would be maintained at eight weeks post-training and these scores would be higher than the group who had no exposure to the GPA course, and (c) staff members who had received the GPA training would describe using person-centered skills more frequently than the individuals who had no exposure to GPA. The wait-listed groups received standard support from a clinical nurse educator on behavioural management when the staff requested assistance. Results from the study showed that staff members in the intervention group had a statistically significant improvement in their self-efficacy scores from baseline to immediately post intervention, and the results were sustained at 8 weeks post intervention (Schindel Martin et al., 2016). There was also a large difference in self-efficacy scores between the individuals who participated in the GPA training and the wait-listed group at 8 weeks post-training. Participants who received the GPA training reported at eight weeks that they were able to use person-centered skills and interventions. Individuals in the wait-listed group felt that they did not have the proper skills to manage responsive behaviours and required dementia specific training to better prepare themselves in the workplace.

1.3.3.3 Sustainability of GPA training. Gillies, Coker, Montemuro, and Pizzacalla (2015) identified the key factors influencing the sustainability of GPA during the implementation of the GPA project in two acute care sites in Ontario, Canada. These factors included relevance of the issue, networks and stakeholders, leadership, policy articulation, and financial resources. Results showed that sustainability occurs when (a) participants find the information from the GPA training applicable to their learning needs (e.g., the program was able to address a lack in understanding about delirium), (b) there are champions for the program (e.g., clinical nurse specialist, nursing aides, therapists), (c) leadership (e.g., senior leadership team of the acute care site, manager) advocates for the program, (d) the principles of the GPA program are integrated in

policy and procedures (e.g., GPA approaches are first line of management of responsive behaviours versus restraint usage), and (e) there is financial support to enable the training and recertification to continue.

1.3.4 Implementation and Evaluation of the GPA Program in a Large Health Region on the Canadian Prairies

1.3.4.1 Stage one of the implementation and evaluation of the GPA program. The implementation process and evaluation of the GPA program was completed by the first author in three stages between 2008 and 2011. Stage one began in September 2008, in one rural LTC home. A qualitative questionnaire was completed by staff three months after receiving the GPA 7.5 hour training. They were asked to describe a situation in which they used the GPA skills with a resident and explain how the resident responded to the interaction. Results from this questionnaire showed that the interactions that occurred when staff members used the GPA skills ended in a positive tone. The residents were calmer and this made it easier for staff to work with the residents.

1.3.4.2 Stage two of the implementation and evaluation of the GPA program. Stage two of the implementation and evaluation of the GPA program occurred in two care homes (one rural and one urban) in December 2009. The Director of Care in the rural home chose to evaluate the GPA program by measuring the number of responsive behaviours displayed by five residents (n=5) in the care home over a 12-month time frame (December 1, 2009 – November 30, 2010). The residents were selected by the Director of Care (DOC) based on a higher incidence of responsive behaviours. A chart review was completed three months prior to the implementation of the GPA program to establish the baseline for the number of times the staff charted that the residents displayed verbally responsive behaviours and physically responsive behaviours. Incidents of yelling, swearing, screaming and calling out as verbally responsive behaviours and hitting, kicking, scratching, pinching and biting as physically responsive behaviours. Results of the chart audit showed that there was a 34% decrease in the number of reported incidents of verbally responsive behaviours and an 80% decrease in the number of incidents of physically responsive behaviours reported.

The Director of Care in the urban care home chose to evaluate the GPA program by examining the number of anti-psychotic and anti-anxiety medications ordered *pro re nata* (as needed; PRN) and administered to residents displaying responsive behaviours during a 9-month

time period (December 1, 2009 – September 1, 2010). Charts were reviewed over a three-month period prior to the implementation of the GPA program and reviewed every three months after the implementation. Although statistical analyses were not conducted, results indicate that at baseline review, 51.2% of residents within the home had an order for a PRN anti-psychotic or anti-anxiety medication. At nine months, only 26.3% of residents had an order for a PRN anti-psychotic or anti-anxiety medication. In addition, the number of times that a PRN anti-psychotic or anti-anxiety medication was administered decreased from 139 at baseline to 15 after nine months. Based on the evaluation of the GPA program, this program was implemented into the remaining LTC homes in the health region.

1.3.4.3 Stage three of the implementation and evaluation of the GPA program. The third stage in the evaluation of the GPA program occurred after the program had been implemented in 25 LTC homes within the health region. The effectiveness of the program was measured using the *Perceived Competency Scale (44 questions)* and the *Behavioural Agitation Attitudes and Values Clarification Scale (12 questions)* in 12 LTC homes. For the Perceived Competency Scale, participants were asked to select an answer on a five-point Likert Scale (1 = "I find this skill difficult" to 5 = "This skill is natural and automatic") that measured their competency of the skill. For the Behavioural Agitation Attitudes and Values Clarification Scale, participants were asked to select an answer on a five-point Likert Scale (1 = mostly disagree to 5 = mostly agree) that assessed their attitudes and values related to residents with dementia who display responsive behaviours. Participants were asked to complete each scale at three points in time (pre-training, post-training, and six weeks post-training).

Data were collected from the 12 homes over a two-year period (2009-2011). A total of 2070 surveys were completed. Of the 2,010 surveys completed, 999 were randomly sampled from each time period (pre-training, post-training, and six weeks after training). Nineteen questions (n=19) were selected from the Perceived Competency Scale and the Behavioural Agitation Attitudes and Values Clarification Scale to be analyzed. The questions that were selected were those that assessed the main GPA curriculum content related to understanding and managing responsive behaviours. See Table 1.1 for questions that were selected from the Perceived Competency and Attitudes and Values Clarification Scales. Staff reported an improvement on all questions in both scales immediately after they received the GPA training. At six weeks post-training, staff ratings remained above pre-test scores on all 19 questions. From

post-training to six weeks after training, staff ratings decreased on twelve of the nineteen questions and increased or remained the same on seven of the nineteen questions.

Table 1.1

Questions from the Perceived Competency and Attitudes and Values Clarification Scales

Question
1. I have a clear understanding of how changes in the brain result in challenging behaviours.
2. I am able to identify triggers of challenging behaviours in persons with dementia.
3. I am able to identify signs and symptoms of impending challenging behaviours.
4. In communicating with a person with dementia, I avoid arguing and confrontations.
5. I validate and respect the resident's feelings in whatever time or place is real to him/her.
6. I understand that the way I communicate with resident's impacts on how the resident receives and responds to the message.
7. I know when I've been dismissed – "Stop and Go" approach.
8. I use physical interventions only as a last resort.
9. I remember that verbally defensive behaviour will not hurt physically and I don't overreact.
10. After a situation, I look for treatable causes (i.e. infections).
11. In de-escalating a situation, I offer continued support to the resident.
12. In de-escalating a situation, I help the resident express their feelings.
13. After a situation, I inform supervisors and colleagues.
14. After a situation, I look after myself.
15. All human beings react inappropriately to threatening things from time to time, and people with dementia are no different.
16. Physically aggressive behaviour should be interpreted as an attempt by the persons with dementia to protect themselves.
17. Staff in my organization use an open-minded and flexible approach to cases of agitated physical behaviour in dementia
18. If people with dementia are given an appropriate avenue for expression of their negative emotions, it will reduce irritability, depression and agitation.
19. Challenging behaviours in a person with dementia means that there is something wrong: an unmet need of some kind that should be addressed.

To date, evaluation of the GPA program implemented in this Canadian Prairie setting has included assessment of attitudes, values, and perceived competency of staff in LTC homes. The number of PRN anti-anxiety and anti-psychotic medications and the number of verbal and physical responsive behaviours has also been examined as described above. The limitation of

these evaluations includes their small scale and short-term time frame. There have not been any attempts to look at program sustainability over a longer period of time. The data collected from the questionnaires suggests that staff are using the GPA skills three months post training, but the factors the contributed to the sustainability of the program are not understood.

1.4 Implementation Science

1.4.1 Movement Toward Implementation Science in Health Care

1.4.1.1 Research gaps. It is well accepted that there is a significant gap between research on intervention effectiveness and the implementation of new knowledge into practice (Bradley et al., 2004; Davis et al., 2003). According to Morris, Wooding, and Grant (2011), it can take between 3 and 28 years on average to implement evidence into practice. In addition to the lag time between knowledge creation and implementation, there is also variability across health care systems in relation to what types of evidence and how much is actually implemented (Greenhalgh et al., 2014). This gap may be related to issues such as the large amounts of information that practitioners are inundated with, or because the evidence does not work as well in a practical setting (Greenhalgh et al., 2014). Graham et al. (2006) reported that patients may not be receiving the best care possible because clinicians are not using current research in their practice.

Historically, the positivistic approach regarding research utilization/knowledge translation was influential in the middle of the 20th century (Huberman, 1994; Kitson, 2009). Academics at the time often focused on completing controlled research trials on selected participants and did not worry about whether or not their findings impacted the quality of life of the intended target group (Bauer, Damschroder, Hagedorn, Smith, & Kilbourne, 2015). The thought surrounding research utilization suggested that there was a unidirectional flow of information from the researchers to the individual practitioner or policy maker (Wingens, 1990). The expectation was that once research was generated (Nutley, Walter, & Davies, 2003), it should be immediately implemented within the health care system (Ilkiw-Lavalle, Grenyer, & Graham, 2002; Nutley et al., 2003).

For those who work in health care, however, passive information or educational activities are very poor methods to create change in a system (Caspar, Cooke, Phinney, & Ratner, 2016; Davis et al., 2003). Unfortunately, passive educational activities appear to be the most frequently used method by individuals attempting to effect change practice in health care (Caspar et al.,

2016). To improve the uptake of knowledge, the health care system needs to move beyond simple dissemination of knowledge (Kitson, 2009). According to Straus, Tetroe, and Graham (2009) knowledge creation, distillation, and dissemination are not powerful enough to cause a change in how knowledge is used. The health care system is a dynamic, chaotic, and ever-changing system where many factors play a role in how knowledge is transferred and disseminated (Davis et al., 2003; Huberman, 1994; Kitson, 2009).

1.4.1.2 Common knowledge translation terminology. There has been a lack of consistency in the terms and definitions used within the literature in relation to knowledge translation (Khalil, 2016). This problem can be partially related to the fact that different countries have used different terms (Khalil, 2016; Rabin & Brownson, 2012). *Dissemination* is a commonly used definition to refer to the strategically planned methods of spreading information about an intervention to a particular user group (Rabin & Brownson, 2012). *Scaling up* refers to the ability to increase the use of successfully tested interventions to improve the benefits for service users and to create long lasting policy changes (Simmons & Shiffman, 2007). *Integrated knowledge translation* has been more commonly used across Canada. According to the Canadian Institutes of Health Research (CIHR), integrated knowledge translation occurs when the knowledge users are involved throughout the entire research process (as opposed to at the end of the grant funding) so that the finalized product is useful and meaningful to those who will use it. Although the term integrated knowledge translation is widely used across Canada, there is a gap within this concept that needs to be addressed. Knowledge translation fails to provide researchers and clinicians with the skills and abilities on how to implement knowledge (Khalil, 2016).

1.4.1.3 Impact of context in implementation. Realizing that there is a gap between knowledge produced and knowledge use, researchers are looking at more effective ways to improve the uptake of ideas, innovations, and programs in the health care setting (Bauer et al., 2015; Casey, O' Leary, & Coghlan, 2018; Nilsen, 2015). To facilitate successful transfer of knowledge within the health care system, we must understand the context (Bauer et al., 2015; Kitson, 2009) of the health care system at the individual, organizational, and social levels to effectively implement best practice guidelines (Dijkstra et al., 2006). Within the context, it is important to note that there are barriers and facilitators to implementation at all levels in the health care system (Bauer et al., 2015). In a systematic review, Flottorp et al. (2013) identified seven domains of factors that influence whether or not practice change occurs. These domains

included: guideline factors, individual health, professional factors, patient factors, professional interactions, incentives and resources, capacity for organizational change, and social, political and legal factors. Examples of facilitators or barriers to implementation under these domains are quality of evidence, clinician awareness and agreement with recommendations, patient motivation to adhere to innovation, health care team functioning and communication processes, availability of resources, capable leadership, and economic constraints on the health care system (Flottorp et al., 2013).

1.4.2 Implementation Science Processes and Frameworks

1.4.2.1 Evolution of implementation science. The field of implementation science has emerged to address the challenges related to the sustainability of programs and innovations in health care settings (Bauer et al., 2015; Olswang & Prelock, 2015). It is defined as the "scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services" (Eccles & Mittman, 2006, p. 1). Evidence emerging from this research area demonstrates that in order to sustain practice change, implementation activities need to be planned and systematic in nature (Khalil, 2016; Olswang & Prelock, 2015) with a focus on and an understanding of the patient, clinician, and the health care system (Bauer et al., 2015; Casey et al., 2018; Olswang & Prelock, 2015). Implementation science is a way to "change the behaviour of providers" so that evidence developed by researchers gets translated as closely as possible in real life health care settings (Bhattacharyya, Reeves, & Zwarenstein, 2009, p. 492). Transferring evidence from a research study into real life clinical practice is a very complex and complicated process. To understand and achieve sustainability of evidence-based based practice, there have been many theories, models, and frameworks developed within the implementation science literature.

1.4.2.2 Stages of the implementation process. To describe the overall implementation of the Gentle Persuasive Approaches Program in a large health region on the Canadian Prairies, the current study uses the terminology developed by Fixsen, Naoom, Blasé, Friedman and Wallace (2005) for the six stages of the implementation process: exploration and adoption, program installation, initial implementation, full operation, innovation, and sustainability. According to these authors, implementation is not a one-time event but a process that happens over time. The stages are not linear and will often overlap. The first phase, *exploration*, happens

when an individual or organization begins to "think about" using an innovation (Fixsen et al., 2005, p. 15). This "thinking" leads to the exploration of the needs of the organization or health care setting and reviewing the evidence that will meet the needs of the stakeholders. A decision on whether the intervention will be used (or not) will occur at this stage. After an organization has agreed to adopt an intervention, there are many tasks that need to be completed before the intervention is introduced to the program users. According to Fixsen et al. these tasks are the defining steps of *program installation* (stage 2): securing appropriate funding, hiring new staff, securing space, purchasing computers and new technology, and training staff.

The third stage of the implementation process is the *initial implementation* (Fixsen et al., 2005). This stage requires change of practice at the individual, contextual, and systemic levels. The change process will not be easy for some individuals, nor will the change happen simultaneously throughout the organization (Fixsen et al., 2005). To maintain the change at the individual and organizational levels, training, education, and time to establish the intervention within their clinical practice must occur. During this phase, the program is struggling to take hold within an organization and the decision to adopt the program is being tested. It is at this time that that new interventions may fail because there is pressure from both internal and external sources in relation to managerial and practice issues.

The fourth stage in the implementation process is called *full operation* which occurs when the program takes root at the individual, organizational, and system levels (Fixsen et al., 2005). This includes aligning all policies, procedures, and practices with the new intervention. This is the stage where the program is running at full capacity with the appropriate staff levels and client load. The act of "doing business" is based on the evidenced-based intervention (Fixsen et al., 2005). Throughout this stage, the intervention is starting to become part of the fabric of the organization. It is accepted by staff and treatment outcomes should be achieved at this point because the staff have acquired and are using the new skills related to the intervention.

The fifth stage of implementation is called *innovation* (Fixsen et al., 2005). Each time a program is implemented within an organization, an opportunity to learn about it is created. It is important to know what parts of the program need to be changed and what information needs to be added in. When changes are made to the program without clinical importance or rationale, a threat to program fidelity occurs. Adaptations that are made to a program can be positive. They improve the effectiveness and sustainability of the desired program outcomes. Given enough

time, there is a possibility that some programs that have been adapted may have changed the look and the functioning of a program so that the overall effectiveness needs to be re-examined.

The sixth and final phase of the implementation process is *sustainability* (Fixsen et al., 2005). According to Fixsen et al. (2005) a program is considered sustained when it has been maintained within the community for several years post implementation. The organization must be able to maintain the program even after well trained staff and leaders leave, political waters change, and champions move on to other employment opportunities. The organizational leadership must be aware of these shifting components and be able to change so that they are still able to maintain the core elements of the intervention.

1.4.2.3 The Promoting Action on Research Implementation in Health Services (PARIHS) framework. The Promoting Action on Research Implementation in Health Services framework (PARIHS) was initially developed by Kitson, Harvey, and McCormack in 1998. The framework has been reconceptualised over several years, most recently in 2015 by Harvey and Kitson. The assumption behind the PARIHS framework is that the likelihood of research evidence being translated into practice is higher when evidence, context, and facilitation are high (Rycroft-Malone, 2010). Each one of these three elements and their sub-elements can be placed on a continuum from low to high. The PARIHS framework focuses on the factors that play a role in the overall implementation process.

To increase the chances of evidence being successfully implemented into practice, research, clinical experience, patient experience, and local data/information should be located on the high side of the continuum. This occurs when research is valid, relevant, and rigorous; clinical experience is based on expertise and consensus; patient experience is valued; and local data/information has been collected, evaluated, and is considered within the decision-making processes of the organization (Rycroft-Malone, 2004). The sub-elements of context that are related to the successful implementation of evidence into practice are culture, leadership, and evaluation. To be high on the continuum, culture must promote learning and value all staff and individuals within the setting, leadership must be transformational in nature and create collaborative teamwork, and evaluation must use various types of feedback systems from all staff and individuals in the health care setting (Rycroft-Malone, 2010).

Facilitation also ranges from low to high. Low facilitation is characterized as inappropriate or no facilitation and high facilitation is defined as the presence of appropriate

facilitation (defined as roles and interventions that meet the needs of the specific situation and context; Rycroft-Malone, 2004). The purpose of facilitation can range from task-focused to holistic. The role of the facilitator can vary from "doing for others" to "enabling others" (Rycroft-Malone, 2004, p. 302) and the skills and attributes of the facilitator can move from task-focused or doing for others to those that are holistic and enabling (depending on the needs of the individuals or the organization; Rycroft-Malone, 2004; 2010). "Skilled facilitators are those that can adjust their role and style to the different stages of an implementation project and the needs of those they are working with" (Rycroft-Malone, 2010, p.119).

1.4.2.4 Critique of the PARIHS framework. The PARIHS framework was refined in 2015 by Harvey and Kitson, as a response to weaknesses identified within the framework and a lack of clarity surrounding the elements of PARIHS and the key term of "successful implementation" (Helfrich et al., 2010). Stetler, Damschroder, Helfrich, and Hagedorn (2011) suggested that although the PARIHS framework was easy to use, was flexible in application, and included the term "successful implementation" as the desired outcome, there were limitations that needed to be addressed. They felt that there was a lack of conceptual clarity, specificity, and transparency which led to different understandings of the PARIHS concepts by different researchers. In addition, several "missing" components were identified. For example, the outcome of "successful implementation" lacked a specific definition, there was little guidance about facilitation and developing needed change strategies, and the framework lacked PARIHS-related measurement tools to analyze and evaluate "successful implementation."

Ullrich, Sahay, and Stetler (2014) also acknowledged strengths and weaknesses of the PARIHS framework. Strengths included: was simple and easy to use, provided general guidance, the key elements addressed constructs related to implementation, and PARIHS worked well with other theories. Weaknesses identified by Ullrich et al. included: too broad with too many constructs, did not speak to specific intervention strategies or tools that were needed for an implementation project, the elements within the framework were not well defined, and there was a lack of valid measurement tools. Harvey and Kitson (2015b) pointed out a number of reasons for revisiting the PARIHS framework. They suggested that (a) the main elements of the PARIHS framework fail to identify the targets for implementation and the wider external context, (b) the framework does not identify the influential role that individuals play in process and outcomes of

implementation, and (c) a synthesis of key theories relating to implementing evidence-based practice is required.

1.5 Conceptual Framework: the integrated Promoting Action on Research Implementation in Health Services (i-PARIHS) Framework

1.5.1 Overview of i-PARIHS

Based on the critique from researchers and users of the PARIHS framework, Harvey and Kitson (2015b) proposed a revised framework called the "integrated Promoting Action on Research Implementation in Health Services" (i-PARIHS). In this framework, successful implementation is defined as: (a) achievement of the agreed upon implementation/project goals, (b) the uptake and embedding of the evidence in practice, (c) individuals, groups, and teams are motivated and own the innovation being implemented, and (d) variation related to the context in which the innovation is being implemented is minimized across implementation settings. Within the newly refined i-PARIHS framework, Harvey and Kitson (2015b) suggested that, "successful implementation results from the facilitation of an innovation with the recipients in their (inner and outer) context" (p. 40).

1.5.1.1 Evidence construct. The "evidence" construct within the PARIHS framework was changed to the broader term of "innovation" in the i-PARIHS framework to reflect how knowledge is created and communicated between individuals and organizations. This innovation is to be thought of as "what" is being implemented. Both explicit and tacit knowledge as well as their impact on practice change are encompassed within the innovation construct (Harvey & Kitson, 2015b). Harvey and Kitson (2015b) suggested that it is pertinent to "focus on sourcing and applying available research evidence to inform the innovation" (p. 42). When evidence is implemented into an organization the following factors of the innovation need to be reviewed: underlying sources of knowledge, clarity, potential fit within the organization, degree of novelty, usability, relative advantage, trialability, and observable results (Harvey & Kitson, 2015b).

1.5.1.2 Recipient construct. The "recipient" construct is also new to the i-PARIHS framework. It was added to address the fact that individuals (who play an instrumental role within the implementation process) were not acknowledged in the original PARIHS framework. Within i-PARIHS, the recipient construct recognizes the role that the individual and the team play in practice change. Harvey and Kitson (2015b) identified several recipient characteristics that must be evaluated during implementation. Motivation, goals, skills and knowledge, time,

resources, and support, as well local opinion leaders, collaboration and teamwork, existing networks, the learning environment, power and authority, and presence of boundaries must all be assessed during the implementation process. They divided these factors into two categories: whether or not the recipients "want to" implement the innovation and whether or not they "can" implement the innovation.

1.5.1.3 Context construct. As in the original framework, the construct of "context" remains; however, the scope of it has expanded to include the inner and outer contexts in implementing an innovation (Harvey & Kitson, 2015b). The inner context is described as the exact place in which the innovation is being implemented and the organization in which the area is situated. This may be a ward within a hospital, or a smaller area within an LTC home. The outer context consists of the larger health care system including the policies, procedures, regulations, and political environment. Within the inner context, the formal and informal leadership support, culture, past experiences with innovation, learning, evaluation, feedback processes, and the mechanisms to create change are important factors to assess during the implementation process. Harvey and Kitson (2015b) described a positive learning organization as one where staff, patients, and residents feel supported and valued, practice change is encouraged, there is continuous feedback and evaluation of the innovation, and the leadership is considered to be humanistic.

At the organizational level of the inner context, there are also characteristics that will impact on the implementation of an innovation (Kitson & Harvey, 2015). The innovation may or may not be in alignment with the organization's priorities. For example, a mandated culture change program designated by the government may be less of a priority than reducing sick leave and work place injuries. The higher the support and the better fit within the organizational priorities, the more likely it will be implemented. Additionally, the structure of the organization (hierarchical versus inclusive) and how the organization has handled organizational change historically will be indicative of the successfulness of the innovation. Although more difficult to change, the characteristics of the outer context must not be ignored during the implementation of an innovation. These include the regulations, financial incentives (or lack thereof), and the strength of the inter-organizational mechanisms to spread the information gained from the new innovation (Kitson & Harvey, 2015).

1.5.1.4 Facilitation construct. The construct of facilitation is the mechanism for change as it is a planned and coordinated process. It is the "how component of implementation" (Harvey & Kitson, 2015b, p. 47) because it "activates" the overall implementation process. Facilitation requires an individual(s) with a set of skills who has an understanding of the innovation they are implementing, the context in which the program is being implemented, and the individual employees who are required to change their practice. The role of facilitator may be formal or it may be completed by someone within the organization, like a clinical leader, who has the skills and attributes to bring about change. The complex role and functioning of facilitation within the i-PARIHS framework will be discussed in more detail below.

1.6 Facilitation

1.6.1 The Role of Facilitation in Creating Behaviour Change

1.6.1.1 Facilitation in the PARIHS framework. Facilitation is a term that can be found in different areas within the literature including ecology, business, education, health care, and counselling (Simmons, 2004). It has different meanings depending on the field of interest. Facilitation activities may occur as an intervention within the health care literature but often are not reported officially as facilitation (Dogherty, Harrison, Graham, & Keeping-Burke, 2014). This literature review will focus only on facilitation within the area of health care given that there is such a wide range of information available on the topic. In 1998, Kitson et al. proposed that facilitation was one of the main factors influencing the uptake of evidence into practice. They defined facilitation as "making things easier for others" (Kitson et al., 1998, p.152). In 2002, Harvey et al. completed a conceptual analysis surrounding the concept of facilitation within the PARIHS framework. This analysis was completed to establish the conceptual clarify of facilitation as part of the ongoing refinement of the framework. According to Harvey et al. (2002) facilitation is the "process of enabling (making easier) the implementation of evidence into practice" (p. 579). This definition implies that facilitation is conducted by a particular individual, within a specific role, designed to help out others. The analysis also identifies that the role of a facilitator is one that is (a) formal and agreed upon, (b) internal or external to the organization, and (c) helps staff as opposed to convincing or influencing them. A facilitator, therefore, is an individual who has the skills and attributes to help all individuals within an organization implement best practice.

The conceptual analysis also provided a detailed discussion of the purpose, roles, skills, and effectiveness of facilitation. Harvey et al. (2002) described each one of these as occurring on a continuum. The *purpose* of facilitation ranges from helping individuals attain a goal to assisting in establishing ways to create change in behaviour within a system. If the purpose of the facilitation is on the end of the spectrum where a goal is being met, the role of the facilitator will be focused more on providing practical support. If the purpose of the facilitation is to create change within an organization, the facilitation role will change to that of helping and enabling. In order for a facilitator to be effective within an organization, they must have a wide range of *skills and attributes* (Harvey et al., 2002). If the facilitator is focused on achieving a goal or completing a task, the skills that they may need are more technical in nature (i.e., project management skills). If the facilitator is focused on enabling others, the skills that they may require include flexibility, relationship building, and authenticity. In summarizing studies evaluating the *effectiveness* of facilitation interventions, Harvey et al. (2002) concluded that despite the development of the concept of facilitation "it is difficult to isolate which aspects of the facilitation process or the facilitator role are more or less effective in influencing change" (p. 585).

1.6.1.2 Facilitation as the active ingredient to behaviour change in the i-PARIHS framework. With the reconceptualization of the PARIHS in 2015, the new i-PARIHS framework maintained facilitation as a component, but further highlighted facilitation as the "active ingredient" in the implementation process (Harvey & Kitson, 2015a, p. 47). Innovation, recipients, and the inner and outer contexts are 'integrated' through facilitation (which is purposeful and planned) by individuals with the unique skills to create practice change (Kitson & Harvey, 2015). Within i-PARIHS, the main characteristics of facilitation included involvement of key stakeholders, participant ownership, providing feed-back at the time of performance, empowerment, and enablement of individuals within the organization. Kitson and Harvey (2015, p. 75) have identified the differences between "being a facilitator" and "doing" facilitation and these terms have their roots in the early PARIHS terminology of skills, roles, and attributes as sub-elements of facilitation. Attributes of 'being a facilitator' included someone who is fearless, resilient, curious, and patient. 'Doing facilitation' includes establishing rapport and trust with individuals, building a cohesive and effective team, teaching, and creating a learning environment, and completing tasks on time. Harvey and Kitson (2015a) suggested that

facilitators need to be flexible and have the ability to adapt how they facilitate relative to the particular innovation, recipients, and context.

One of the major critiques of the PARIHS framework was that facilitation was difficult for individuals and teams to use in everyday settings (Stetler et al., 2011). As a result of this, a "pathway' was created in which facilitators move through the process of starting out as novice facilitator towards becoming an expert facilitator. Novice facilitators need to be supported by individuals who have more experience in facilitation and should be mentored by an expert facilitator. Experienced facilitators should work under the supervision of expert facilitators, and the role of the expert facilitator is to provide coaching and guidance to other facilitators within the system or organization. The idea of support for facilitators has been echoed by other researchers (i.e. Dogherty, Harrison, Graham, Vandyk, & Keeping-Burke, 2013; Harvey & Lynch, 2017).

Harvey and Kitson (2015a) have conceptualized the implementation process in the i-PARIHS framework as a continuous spiral. For the facilitator, their journey begins in the middle of the spiral in which they focus their attention on the innovation and the recipients. As the implementation process continues, their focus moves outwards through the inner context (at the local and organizational level) towards the outer context. The facilitator will examine different factors related to the innovation, the recipients, and the contexts, and identify what activities need to be completed for each construct. Harvey and Kitson (2016) hypothesized that as the facilitator progresses through the spiral, they move from the more concrete skills of facilitation (e.g., project management skills) towards those that require more complex skills and experience.

1.6.2 Characteristics, Skills, and Attributes of Facilitators

1.6.2.1 Facilitation in health care settings. Janes, Fox, Lowe, McGilton, and Schindel Martin (2009) conducted one of the few studies related to facilitation within LTC settings. Their study was designed to explore the factors that impact on whether or not nursing staff use research in their practice through facilitation, from the perspective of the facilitators. Participants identified individual factors related to the facilitator's approach and traits, and the emotionality and intellectual capacity of the receivers (nursing staff). The three factors related to the approach of the facilitator were framing, engaging, and bridging. Facilitator traits included flexibility, experience, and emotional maturity. Characteristics of receiver emotionality were defined as feelings, motivation, and attitude.

According to Janes et al. (2009) participants identified leadership, culture, and workload as contextual factors that impact on the implementation of evidence-based practice. Managers must support the use of research in practice through role modelling and being enthusiastic. Leaders must also ensure that there is a positive relationship between nursing staff and administration. In addition to strong leadership, an organization must promote a culture of practice change, and arrange for staff to have time away from their workload to be able to focus on ways to implement research in their clinical practice. Many of the factors identified at the individual and contextual levels were affective and relational (Janes et al., 2009). Working in LTC homes is not an easy job. It is challenging, unpredictable, and often very stressful. When staff react to these conditions with negative feelings and attitudes, the chances of changing practice decreases.

Within the PARIHS framework respect, empathy, and credibility of facilitators are identified as factors that are likely to increase the chance of evidence being implemented in practice. Janes et al. (2009) suggest that engagement, framing, and experience are linked to the characteristics defined in the PARIHS framework; however, the framework does not address the emotional maturity of the facilitator. Janes et al. agree with Harvey et al. (2002) that it is not known what facilitation skills are required in LTC homes and that there is very little consensus about the most effective method of facilitation for helping staff effectively implement research findings in their daily practice. “Empowering styles of leadership and emancipatory approaches to facilitation require further research in the interest of promoting the social interactions within LTC homes most conducive to nursing staff utilization of best practice knowledge” (Janes et al., 2009, p. 174).

Dogherty et al. (2013) proposed that the subject of facilitation is not well defined in Canada. They suggested that there are many individuals across the Canadian health care system who play a facilitator role and use facilitation skills as a part of their job but are not referred to as official “facilitators.” Researchers do not have a good understanding of the role or the function that nurses play in facilitating evidence-based practice. To delve further into this unknown area of nursing practice, Dogherty et al. invited 20 nurses from across Canada to discuss their experiences as facilitators in relation to implementing evidence-based practice. Few of the nurses within this study identified as being “facilitators” and many other titles were used in place of facilitators (e.g. Clinical Leader, Advanced Practice Nurse, or Project Lead). This is a similar

finding to that of Harvey and Kitson (2015a) and Harvey and Lynch (2017) who believe that facilitation can be done by many individuals within an organization, in contrast to earlier conceptualizations of the facilitator as a formal role (Harvey et al., 2002).

The attributes, skills, and characteristics that the nurses identified as leading to successful implementation in the study by Dogherty et al. (2013) were similar to what Kitson and Harvey (2015) and Janes et al. (2009) identified in their research on facilitation. Flexibility, resilience, credibility, relationship building skills, using multiple facilitation strategies, engaging individuals and teams, not shying away from conflict, and relying on positive communication skills were just a few of the areas in which Dogherty et al., Kitson and Harvey, and Janes et al. overlap in their research related to facilitation. Although Dogherty et al. (2013) did not officially use the terms innovation and recipients as used in the i-PARIHS framework, they described three important factors that impact successful implementation that would fall under these two constructs: the development of partnerships and engagement of key stakeholders, importance of the issue (e.g., is the innovation being implemented meeting a need or a problem identified by staff), and characteristics of the evidence. Dogherty et al. (2013) found that the factors related to the context (another i-PARIHS construct) were those that had a negative impact on successful implementation (e.g. lack of resources, conflictual relationship throughout the organization, staffing issues, lack of evaluation). These authors recommended that prior to implementing evidence-based practice into an organization, facilitators should recognize that there will be contextual issues and establish a plan to overcome these barriers prior to the start of the implementation process.

1.6.2.2 Refinement of facilitation in health care. Dogherty et al. (2014) conducted a systematic review to gain an understanding of facilitation as it related to the implementation of best practice guidelines in nursing and they concluded that because facilitation activities are often not reported in the literature it may be a larger topic that is used in conjunction with other strategies to implement evidence-based practice. It is therefore important to conduct further research studies to uncover the relationships between facilitation and other implementation strategies (e.g. communication strategies, interactive learning opportunities, audit and feedback mechanisms, reminders). Future research should be aimed at studying individuals who are "doing" facilitation within their own health care setting to gain an understanding of what these

clinicians are naturally doing and how they are doing it in relation to implementing evidence-based practice.

Researchers have maintained that facilitation as an implementation strategy has shown promise as a mechanism to create change within an organization (Harvey & Kitson, 2016; Harvey & Lynch, 2017; Ritchie, Parker, Edlund, & Kirchner, 2017). Harvey and Kitson (2016) suggested that further studies (prospective and longitudinal in nature) need to be conducted to (a) ensure that all of the constructs within the i-PARIHS framework have been accurately described, (b) further understand the relationship between the constructs and how they impact the implementation process, (c) examine the fit and utility of the i-PARIHS framework for diagnostic and evaluative purposes within health care and (d) assess the theoretical underpinnings of each construct. This will allow future researchers to then evaluate the effectiveness of facilitation as an implementation strategy (Harvey & Kitson, 2016; Kitson & Harvey, 2016). Harvey and Lynch (2017) specifically recommended that it is important to study the core elements of facilitation, what is and is not considered a facilitation intervention, as well as the "dose, frequency, and intensity of facilitation" (p. 4).

1.6.2.3 Change agency roles. Harvey et al. (2002) suggested that there are other roles that are effective in creating change within a system. These roles have different names within the literature ranging from champions, opinion leaders, academic detailers, or boundary spanners. It is sometimes difficult to discern between these roles due to various terms used and the lack of definitions provided within the literature (McCormack et al., 2013). Harvey et al. noted that it was difficult to make a clear distinction between the role of facilitation and other change agents (e.g., champions and local opinion leaders). Educational outreach workers (sometimes called academic detailers) are trained individuals who provide information to clinicians to create change in their practice (Harvey et al., 2002). A local opinion leader is someone who is viewed as influential who creates change as a result of their influence in the workplace. Opinion leaders are internal while educational outreach visitors are external (Harvey et al., 2002).

Locock, Dopson, Chambers, and Gabbay (2001) examined the role of an opinion leader in improving clinical effectiveness. The aim of their article was to provide some clarity around the term opinion leader and fill in some of the gaps in the literature surrounding who these individuals are and what they do. They defined opinion leader as an individual who is "perceived as having particular influence on the beliefs and actions of their colleagues in any direction,

whether positive or negative" (p. 746). Locock et al. found that opinion leaders typically emerged informally from within the organization, had a strong influence, control of information, and were those individuals who had experience in clinical settings and understood the reality of health care. They reported that there are several different spectrums that opinion leaders may be placed on (Expert to Peer, Support to Hostile, Committed to Non-Committed, Corporate to Individualistic, Enthusiastic to Disaffected, Optimistic to Cynical, Conformist to Deviant, Professional to Executive, and Leading by Instruction to Leading by Example).

Given that there is significant diversity in this role, it is difficult to create a sound definition of opinion leader and it is almost impossible to isolate this role (Locock et al., 2001). The position of opinion leader is embedded in the fabric of the context of the particular site in which the opinion leader works. Locock et al. (2001) suggested that experts or clinical opinion leaders are important in implementing research initially, and peer opinion leaders are important when the actual intervention is taking place. "Before we can determine whether and how opinion leaders bring about change, we need to understand how they are socially constructed in a variety of local conditions" (Locock et al., 2001, p. 745).

Thompson, Estabrooks, and Degner (2006) conducted a review of the various terms related to facilitation. They felt that the roles of opinion leader, facilitator, champion, linking agent, and change agent had more identified similarities than differences. The underlying premise is that each one of these roles created behavioural change through interpersonal contact. They suggested that the difference lies in how some of the roles influence change and the range in which their influence flows. Opinion leaders and change agents are considered experts, whereas champions advocate and promote the program within their department (Thompson et al., 2006). Linking agents are responsible for connecting organizations with the information that they require to create change. In terms of influence, champions and linking agents have little impact on research implementation beyond the intervention of the program that they are connected to. Facilitators typically have influence beyond a specific project; their influence stretches across professionals and other organizations (Thompson et al., 2006). Another difference between these change agent roles is the amount of time that is spent within an organization. The person who is connected to the organization or department most likely will remain for longer periods of time (i.e., champion and/or opinion leader; Thompson et al., 2006). Facilitators more often than not

will have a limited time period within the organization as the projects or interventions are shorter in duration (Thompson et al., 2006).

Stetler et al. (2006) conducted a study related to external facilitation. Individuals in this study were not identified as internal facilitators, but internal change agents. These internal change agents were further identified as clinical champion, opinion leader, site coordinator, site leader, or site team leader. External facilitators assisted 'internal change agents' in problem-solving, communication, and support. Stetler et al. concluded that there are still some gaps around how the problem solving skills of a facilitator are different from the roles of educational outreach/academic detail workers, opinion leaders, or champions. Educational outreach workers/academic detail workers do not look at the context of an environment whereas facilitators are engaged on a broader spectrum (Stetler et al., 2006). Stetler et al. agrees with the findings from Harvey et al. (2002) in that facilitation (which is a distinct role) needs to be planned, well thought out, and create change in a culture through the implementation of research evidence. Stetler et al. do suggest that the concept of facilitation needs to be further clarified by examining different contexts, types of evidence, and the role of internal versus external facilitators.

Kitson and Harvey (2015) described the role of individuals who create change as occurring along a continuum. At one end of this proposed continuum roles would be more task focused and directive related to the implementation process, but at the other end the roles would be more enabling and rely on establishing relationships with individuals and teams. The roles in the middle would be concerned with the exchange of information throughout an entire organization. Kitson and Harvey (2015) suggested that instead of trying to find out more information about the differences between the roles and the activities that are performed, it is important to recognize the ability of these roles to create change. In their opinion, a good facilitator pulls together these individuals (i.e., opinion leaders, academic detailers, knowledge brokers, boundary spanners, knowledge managers, project managers, and change champions) to create an environment for successful implementation of evidence-based practice.

Cranley, Cummings, Profetto-McGrath, Toth, and Estabrooks (2017) completed a scoping review of the facilitation literature to identify the types of facilitation roles and the characteristics of facilitation that have been shown to lead to the use of evidence-based practices in health care. Their review highlighted nine similar terms to those identified by Thompson et al.

(2006), Stetler et al. (2006), and Kitson and Harvey (2015). They included: opinion leaders, coaches, champions, research facilitators, clinical or practice facilitators, outreach facilitators, linking agents, knowledge brokers, and internal or external facilitators. These terms are categorized by whether or not they are (a) internal, external or a combination of internal-external to the organization, (b) formal or informal roles, (c) if they are facilitators or boundary spanners, and (d) trained or not for their role (Cranley et al., 2017).

The review by Cranley et al. (2017) concluded that opinion leaders, coaches, champions, research facilitators, clinical and practice facilitators, and outreach facilitators are mostly internal to an organization while outreach facilitators, linking agents, and knowledge brokers are more often than not external. Knowledge brokers, linking agents, and internal-external facilitators are classified as having roles that span across boundaries (Cranley et al., 2017). Opinion leaders are typically considered to be an informal role which is reflective of the definition by Harvey et al. (2002) and Locock et al. (2001). The remaining eight roles are considered to be formal roles, but staff members in some of these positions may or may not have the appropriate training (Cranley et al., 2017). Coaches, champions, knowledge brokers may or may not have training depending on the studies that were reviewed by Cranley et al. (2017), whereas research facilitators, outreach facilitators, and clinical or practical facilitators have training, along with linking agents.

Opinion leaders are influential on their peers, and are considered to have clinical expertise (Cranley et al., 2017). Cranley et al. (2017) did not describe opinion leaders as having both negative and positive influence on co-workers as Locock et al. (2001) did. Coaches role model, motivate (as do champions), and have leadership skills (Cranley et al., 2017). Champions have a deep rooted and vested interest in the innovation or program that is being implemented. They have been described as visionaries amongst their peers. Research facilitators provide education and support for research that is being conducted in a clinical setting, while clinical or practice facilitators work with individuals surrounding issues that are practice based (Cranley et al., 2017). Leadership skills are required in both of these roles, however, clinical or practice facilitators tend to have an enabling leadership style. Outreach facilitators perform tasks (e.g. audit and feedback, educational visits) related to quality improvement issues. These individuals tend to be medical professionals (physicians and nurses) who are credible and approachable. Linking agents and knowledge brokers act as intermediaries between two organizations, while

external facilitators provide support to the facilitators who are internal to the organization (Cranley et al., 2017).

1.6.2.4 Refinement of facilitation and change agency roles. This overview of the literature related to different change agency roles highlighted the fact that there are similarities and differences between the skills, attributes, and position of facilitation roles within the organization of each of these roles. The research also emphasized the intricate nature of facilitating evidence-based practice and the need for these roles in health care. Further research needs to be conducted on (a) the difference between the various types of change agents and facilitators, (b) "how" and in "what situations" change is sustained, and (c) which processes within the role of facilitation are more effective in implementing evidence-based practice (Harvey et al., 2002). Dogherty et al. (2014) agree with Harvey et al. (2002) recommending that future research needs to focus on the overlap and the differences between facilitation and other change agency roles that occur within health care. Cranley et al. (2017) expressed a need for research to occur in Canada, particularly in LTC and home care, due to the lack of research surrounding facilitation in these settings.

1.7 Sustainability and Leadership

1.7.1 Sustainability and Conceptual Clarity in Health Care

Sustainability is an important concept to focus on within the health care system, where there is a continual push to provide more training, more programs, and more services for patients, clients, residents, and staff (McMillan, 2014). When additional services and training programs are implemented, there is a significant cost in terms of financial, technical, and human resources (Shediac-Rizkallah & Bone, 1998). Despite substantial investment of resources to begin some interventions, many interventions are not sustained or continued as initially planned over the long term (Fleiszer, Semenic, Ritchie, Richer, & Denis, 2015a; O'Loughlin, Renaud, Richard, Gomez, & Paradis, 1998; Shediac-Rizkallah & Bone, 1998; Stirman et al., 2012). It does not seem prudent given the current economic forecast in the western world to invest unnecessary resources on an intervention if it is not sustained.

1.7.1.1 Sustainability terminology. Information about sustainability can be found in the literature under the areas of medicine, education, justice, program development, organizational change, and health. Definitions of sustainability have evolved from these areas because the need for programs and innovations to be sustained long term is universal (Moore, Mascarenhas, Bain,

& Straus, 2017). Each of these fields has different ideas on what sustainability is, what is being sustained, how sustainability should be defined, and when sustainability is achieved (Scheirer & Dearing, 2011). It is difficult to begin to understand sustainability because there is diversity within and across the different areas in the literature in relation to the terminology that is being used (Moore et al., 2017; Scheirer, 2013; Scheirer & Dearing, 2011; Stirman et al., 2012), the timelines and methods used to assess sustainability (Stirman et al., 2012), as well as what is being sustained (delivery of a program or health care provider behaviour change), and the multiple layers in which sustainability can happen (e.g., community, system, organization, patients, or practitioners) (Moore et al., 2017). Additionally, an agreed upon research paradigm, or set of procedures to study sustainability has not been defined in the literature (Moore et al., 2017; Scheirer & Dearing, 2011; Tricco et al., 2015).

Some of the terms used to define sustainability include ownership, capacity building, maintenance, continuation, durability, institutionalization, routinization, appropriation, confirmation, embedding, stability, normalization, and integration (Fleiszer, Semenic, Ritchie, Richer, & Denis, 2015b; Johnson, Hays, Center, & Daley, 2004; Loman, Rodriguez, & Horner, 2010; Moore et al., 2017; Scheirer, 2013; Scheirer & Dearing, 2011; Shediac-Rizkallah & Bone, 1998). *Sustainability*, *institutionalization*, *adhere*, and *maintain* tended to be the terms that appeared most often in the literature when researchers refer to the continuation or maintenance of a program or innovation (Johnson et al., 2004; Stirman et al., 2012; Tricco et al., 2015). Institutionalization can be defined as how a program persists (Shediac-Rizkallah & Bone, 1998; Moore et al., 2017) or becomes implemented in the daily operations of the organization (Johnson et al., 2004). This term tends to look at the organizational or the systemic levels of change (Moore et al., 2017). Sustainability is broader in nature than institutionalization (Fleiszer et al., 2015b) and recognizes that there is a "diversity of forms that this process may take" (Shediac-Rizkallah & Bone, 1998, p. 92). Sustainability is a dynamic, multifaceted process which happens in different contexts, at different times with different results (Fleiszer et al., 2015b; Scheirer, 2005; Scheirer, Hartling, & Hagerman, 2008; Shediac-Rizkallah & Bone, 1998). It is a process that is flexible and not limited only to the survival of an idea, innovation, program, or initiative within a particular organization (Shediac-Rizkallah & Bone, 1998).

1.7.1.2 Perspectives on sustainability. Shediac-Rizkallah and Bone (1998) suggested that there are three different perspectives related to the definition of sustainability. These

included definitions that look at how to maintain the benefits of an intervention, how interventions succeed within an organization, and how to build the skill set of an entire community. The authors drew on literature from public health, organizational change theories, and community development to clarify the concept of sustainability. Within the public health literature, the focus of sustainability is on maintaining or continuing the behaviour change related to disease prevention programs. It is important that those who are responsible for the intervention ensure that the sustainability plan contains more than one way to reinforce the behaviour change (i.e., multiple intervention strategies, booster sessions) and that the intervention remains in place to help the next generation of individuals. Long-term strategies for sustainability are required (Davies, Tremblay, & Edwards, 2010). Within the organizational change literature, sustainability is viewed as the final destination in a process that occurs over time (Shediac-Rizkallah & Bone, 1998). The intervention that is being implemented needs to be 'routinized' into the organization so that, eventually, the program loses its own identity and becomes part of the fabric within the organization. The community development literature focuses on building the skills within the community at large. It is believed that the more the community participates in problem solving, the more likely behaviour change will occur and be sustained (Shediac-Rizkallah & Bone, 1998).

Stirman et al. (2012) highlighted in their review that many of the studies in the area of sustainability focus on the general idea of the continuation of benefits of programs or innovations after initial implementation. A focus on the continuation of benefits makes the interpretation of study results difficult, particularly if only portions of the program or innovation remain. Additionally, Stirman et al. found that many studies did not identify a definition of sustainability or a sustainability framework. Stirman et al. recommended that a definition and a framework be identified to guide the research process so that study findings can be interpreted with confidence. Researchers must take into consideration several factors in selecting a definition and ensuring that they identify their research questions. The factors that must be considered when selecting a definition include (a) whether or not the core elements of the program or intervention are being used and to what extent they are being used; (b) whether or not the targeted outcomes of the program or intervention are being maintained after funding is no longer available; (c) tracking of the modifications and the effect of these modifications have on the core and adaptable elements of the intervention; and (d) the ability to function at the appropriate levels as identified to maintain the health benefits.

When reviewing the topic of sustainability, Fleiszer et al. (2015b) identified three characteristics related to the definition of sustainability that consistently appeared within the literature (similar to those identified by Shediac-Rizkallah & Bone, 1998). These characteristics included: innovation related benefits, continuation of the innovation or program, and the advancement of the context or innovation across a long period of time. Fleiszer et al. (2015b) identified these as the characteristics (or attributes) within their conceptual model as benefits, routinization/institutionalization, and development. Benefits of an innovation may be looked at in two different ways: (a) as the measurable achievement of program goals for clients, organizations, or the larger health care system; or (b) the perceived achievement of outcomes by the clients, organizations, or health care system. Routinization or institutionalization is defined as when the skills, processes, and required structures that support the program have become a part of normal, everyday functioning. Finally, the concept of development looks at the process of continuous change for either the innovation or for the individual or organization.

Based on a review of 209 research articles related to sustainability, Moore et al. (2017) created a definition that included five characteristics related to both individual- and organizational-level sustainability. They suggested that after a period of time, the innovation or program continues to be delivered and/or behavioural change at the individual level is maintained. Additionally, the practitioner's behaviour and/or the program may change or evolve over time while the benefits are still being produced at the micro, messo, and macro levels. There are a few differences in this definition of sustainability and those of Stirman et al. (2012) and Fleiszer et al. (2015b). Stirman and colleagues do not discuss behaviour change in their definition and they suggested that sustainability should be assessed over several years instead of at a single point in time. Moore et al. recommended that the time period selected for sustainability depends on the type of innovation or program that is being implemented and the outcomes that have been identified. Fleiszer et al. (2015b) did not mention time as a construct in their definition of sustainability. Finally, in their work, Moore et al. differentiated the terms of institutionalization and routinization where Fleiszer et al's (2015b) does not. Institutionalization is classified as change at the organizational or systemic levels, while routinization focuses on the individual level changes.

1.7.1.3 Linking sustainability and i-PARIHS framework. The term sustainability will be used throughout this research because it encapsulates the multiple, chaotic, and ever-changing

processes that happen during the continuation of a program rather than the term institutionalization which is less broad in nature (Shediac-Rizkallah & Bone, 1998). Kitson et al. (1998) and Harvey and Kitson (2015a) use the term *successful implementation* to describe the use of research evidence in daily practice. Successful implementation occurs when the agreed upon implementation goals have been met, the program or innovation is being used in practice, the practitioners and the end users of the program feel as if the program belongs to them, and the contextual variation has been diminished across the settings in which the innovation has been implemented. Although the term "sustainability" is not specified within the PARIHS and i-PARIHS framework, it is implied in the language they used to describe successful implementation. For example, the developers of the PARIHS and the i-PARIHS framework used the following terms: change, uptake of knowledge, change process, practice change, and success (Harvey et al., 2002; Harvey & Kitson, 2016; Kitson et al., 1998; Rycroft-Malone, 2004). These terms imply sustainability within a clinical setting, which is the outcome of facilitators possessing the appropriate skills, tasks, and attributes by understanding the innovation and working with the recipients within their inner and outer context to enable change (Harvey & Kitson, 2015b). The term sustainability will be used in this research as referring to successful implementation. Specifically, this research focused on the short-term sustainability (15 months) of the Gentle Persuasive Approaches.

1.7.2 Sustainability Outcomes, Factors, Processes, and Interactions in Health Care

1.7.2.1 Sustainability outcomes. There is variability across the literature related to the outcomes of sustainability (Stirman et al., 2012). According to a concept analysis completed by Fleiszer et al. (2015b), the development of sustainability outcomes is in its infancy and many researchers have different understandings of this topic. They determined that there was disagreement within the literature about the nature of "what" is to be sustained of a program or innovation. Additionally, there is little clarity surrounding how many components of an innovation need to be sustained to be considered successful due to the issue of adaptability of a program over time. Fleiszer et al. (2015b) found that, generally, sustainability outcomes were viewed along a continuum ranging from sustained practice change to the cessation of change. These results confirmed the findings from Stirman et al. (2012) who found that partial sustainability was identified more often in the literature compared to entire program or innovation sustainability.

Fleiszer et al. (2015b) reported that sustainability outcomes can be viewed from the individual, organizational, community, and larger health care system levels. Tricco et al. (2015) found that patient level outcomes as opposed to system level outcomes were reported more frequently in the literature. In contrast, Moore et al. (2017) found that an overwhelming majority of the studies that they reviewed looked at organizational/system sustainability outcomes. A small number of studies only looked at the individual level outcomes in synthesis of the sustainability literature. They recommended that future researchers and organizations who are implementing a program or innovation should identify what it is that needs to be sustained at the individual, organization, and system levels. Based on the concept analysis by Fleiszer et al. (2015b), they recommended that more research on refining and developing the concept of sustainability outcomes is required in future studies.

1.7.2.2 Factors impacting sustainability. It is important to examine the factors that impact the sustainability of programs and innovations. Within the literature, there are many different categories of factors that impact sustainability (Fleiszer et al., 2015a, 2015b; Higuchi, Davies, & Ploeg, 2017; Moore et al., 2017; Scheirer & Dearing, 2011; Stirman et al., 2012). However, there tends to be some inconsistency within the literature on what the categories are and how they are defined. Shediac-Rizkallah and Bone (1998) suggested that there are three different factors that are related to sustainability: project design and implementation factors, organizational setting, and community environment. Evashwick and Ory (2003), Savaya, Spiro, and Elran-Barak, (2008), and Scheirer (2005) adapted the categories that were created by Shediac-Rizkallah and Bone (1998). Scheirer and Dearing (2011) identified characteristics of the intervention, organizational setting, and the community environment of the implementing organization as influences on sustainability.

Wallin, Boström, Wikblad, and Ewald (2003) recognized the context of the organization into which the project, innovation, or program is being sustained, but did not divide the context into individual, organizational, or community levels. Maher, Gustafson, and Evans (2007) and Higuchi et al. (2017) suggested that there are process factors, staff factors, and organizational factors that should be examined to increase sustainability. Stirman et al. (2012) and Moore et al. (2017) identified four influences on sustainability: the context (e.g., policies, culture), the innovation (e.g., program fit and adaptability), processes and interactions to sustain the program or intervention (e.g., fidelity, evaluation), and the capacity to sustain the program or intervention

(e.g. available resources, staffing). Fleiszer et al., (2015a; 2015b) noted three of the same characteristics as Stirman et al. (2012) and Moore et al. (2017; i.e., context, innovation, and processes). Instead of capacity, however, they identified leadership as impacting on sustainability.

A commonly cited factor in the literature described above and within the i-PARIHS framework is the construct of innovation (sometimes referred to as intervention characteristics; Fleiszer et al., 2015a, 2015b; Moore et al., 2017; Scheirer & Dearing, 2011; Stirman et al., 2012; Wallin et al., 2003). When examining the sustainability of an innovation, it is important that the users of the program or intervention agree with the innovation, see it as being based on evidence, valuable, or beneficial for themselves and for their patients (Fleiszer et al., 2015a, 2015b; Johnson et al., 2004; Mancini & Marek, 2004; Scheirer, 2005; Scheirer & Dearing, 2011; Stirman et al., 2012). Similarly, sustainability of an intervention is also more likely when the intervention that is being implemented meets an identified need of the community or fits with their mission, vision, values, and strategic plan (Maher et al., 2007; Paine-Andrews, Fisher, Campuzano, Fawcett, & Berkley-Patton, 2000; Pluye, Potvin, & Denis, 2004; Scheirer, 2005; Shediac-Rizkallah & Bone, 1998; Stirman et al., 2012). It is beneficial and important to implement an intervention that has proven to be effective in other settings prior to implementation (Johnson et al., 2004; Shediac-Rizkallah & Bone, 1998; Scheirer, 2005). Additionally, the innovation needs to have fidelity with the ability to adapt the program to the local context (while maintaining core elements; Scheirer & Dearing, 2011; Stirman et al., 2012; Tricco et al., 2015).

1.7.2.3 Processes and interactions influencing sustainability. Processes and interactions were identified by a multitude of researchers as influencing sustainability of an innovation or program (Fleiszer et al., 2015a, 2015b; Higuchi et al., 2017; Moore et al., 2017; Stirman et al., 2012). In their review, Stirman et al. (2012) found that processes and interactions were identified in over 75% of the research articles as being a major factor in sustainability. Fleiszer, Semenic, Ritchie, Richer, and Denis (2016) found that in their study of tertiary urban health care centres educational activities, training programs, and reminders were a few of the processes that were related to positive outcomes for sustaining practice change. One of the most frequently noted predictors of sustainability is the involvement of the stakeholders and/or the community in the negotiation of implementation of the intervention (Johnson et al., 2004;

Mancini & Marek 2004, Stirman et al., 2012). Program effectiveness and evaluation appear frequently in the sustainability literature. Evaluation and feedback of an innovation must occur after implementation of a program (Davies et al., 2010; Evashwick & Ory, 2003; Johnson et al., 2004; Mancini & Marek, 2004; Scheirer, 2005; Shediac-Rizkallah & Bone, 1998). Without evaluation, it is difficult to tell whether or not the program has been successful or sustained according to the previously identified outcome goals. When an evaluation is conducted, it is important that the appropriate research methods are used and the results are conveyed to all stakeholders involved with the program (Mancini & Marek, 2004).

Other processes and interactions identified within the literature include financial, technical, and human resources. Specifically, these included financing (Evashwick & Ory, 2003; Mancini & Marek, 2004; Palinkas, Ell, Hansen, Cabassa, & Wells, 2010; Pluye, Potvin, Denis, Pelletier, & Mannoni, 2005; Savaya et al., 2008; Scheirer et al., 2008; Shediac-Rizkallah & Bone, 1998; Stirman et al., 2012), administrative, secretarial, and research support (Johnson et al., 2004; Mancini & Marek, 2004; Olsen, 1998; Palinkas et al., 2010; Pluye et al., 2005; Wallin et al., 2003), staff trained in program planning (Johnson et al., 2004; Maher et al., 2007; Palinkas et al., 2010), and protected time for staff to complete the activities involved in program planning, implementation, and evaluation (Olsen, 1998; Wallin et al., 2003).

1.7.2.4 The role of context in sustainability. An overwhelming number of articles reviewed for this research identified the context or the organizational setting (often divided into local setting, organizational setting, community setting, and/or larger system setting) as being related to sustainability of evidence-based practice (Evashwick & Ory, 2003; Fleiszer et al., 2015a, 2015b; Higuchi et al., 2017; Moore et al., 2017; Scheirer & Dearing, 2011; Shediac-Rizkallah & Bone, 1998; Stirman et al., 2012;Wallin et al., 2003). The chance of sustaining an intervention improves when the organization is strong, stable, enduring, and established (Evashwick & Ory, 2003; Shediac-Rizkallah & Bone, 1998; Scheirer, 2005), collaboration between team members occurs, support from and partnerships with external agencies (e.g. government) exist (Fleiszer et al., 2015a, 2015b; Higuchi et al., 2017; Scheirer & Dearing, 2011), and the organization values learning (Harvey & Kitson, 2015a). It is also helpful for health care settings to have policies and procedures in place to provide direction and support for the intervention (Johnson et al., 2004; Savaya et al., 2008; Scheirer, 2005; Stirman et al., 2012).

Overlap between the categories and factors related to sustainability indicates that sustainability is a multi-level, multi-factorial process across several layers within the health care system.

1.7.2.5 The role of program champion in sustainability. The sustainability literature speaks to the impact that the role of a champion or advocate has within an organization on the continuation of an innovation (Fleiszer et al., 2015a, 2016; Harvey et al., 2002; Kitson & Harvey, 2015; Stirman et al., 2012). This is also a factor identified within the PARIHS and the i-PARIHS frameworks (Harvey et al., 2002; Kitson & Harvey, 2015). Program champions are sometimes described under the constructs of context, leadership, capacity, or staffing. It is important to recognize this role, regardless of the construct that it is defined under, as being influential in sustainability. A program champion, advocate, or any internal influential individual is necessary to increase the chances of sustaining the program (Kitson & Harvey, 2015; Shediac-Rizkallah & Bone, 1998; Schreirer & Dearing, 2011). The program champion is identified as an individual with leadership abilities who helps to sustain the program. This person, according to Shediac-Rizkallah and Bone (1998) is an individual who is in a senior management position, has negotiation skills, and understands what needs to happen within the organization to create change.

Kitson and Harvey (2015) suggested that change champions are those employees who at a local level and on their own volition, develop an interest in the program or innovation. They work within the organization to help their co-workers accept the evidence-based practice. This role is similar to that of opinion leaders (individuals with the respect and trustworthiness at the local level; Kitson & Harvey, 2015). Change champions influence and encourage their colleagues to change their daily practice within the organization. Johnson et al. (2004) suggested that champions should possess leadership actions and skills to sustain an innovation. In their opinion, a champion is an individual who holds power within the organization and possesses the skills to advocate for the changes required. Champions are responsible for creating links between themselves and the leaders, as well as relationships between the leaders and stakeholders. If required, additional champions and leaders should be recruited to sustain the program (Johnson et al., 2004). Scheirer (2005) and Bass and Judge (2010) also agreed that a program or internal champion is required to sustain change. This person could be the executive director or someone higher up within the organization. Internal or program champions should have access to the senior management team and have some control over the decisions being made. These

individuals should be able to advocate for change, secure resources for program sustainability, and have the appropriate background, training, and credentials to be influential among their peers.

1.7.3 Role of Leadership in Sustainability in Nursing and LTC Homes

1.7.3.1 Conceptual clarity surrounding leadership and sustainability. Studies on leadership within the nursing and LTC home literature focused on skills, strategies, and categories of leadership. Additionally, leadership roles, supportive and relationship building behaviours and characteristics and leadership in relation to person-centered care have all be examined. Essentially, leadership is inevitably required for a new program or initiative to become sustained (Fleiszer et al., 2015a, 2015b; Higuchi et al., 2017; Wallin et al., 2003). However, in the section on program championship above, the terms leadership and leadership skills were included in some of the descriptions of program champions, advocates or opinion leaders. In other articles related to sustainability, leadership, and/or leadership skills and behaviours emerged as a factor separate from program champions. According to Fleiszer et al. (2015b) leadership was defined as being an informal or formal role. These individuals had a specific set of skills and personality features that motivate and create change within an organization. According to their research, the role of program champion was identified under the category of leadership (Fleiszer et al., 2015b). Evashwick and Ory (2003) found that strong leadership is required to champion the new program or initiative within the organization. As evidenced from the articles above, there is a significant gap in the literature related to leadership, as there seems to be little consensus on the position of the role (i.e., is it a formal role, informal role or combination of both), or the behaviours and skills required of leaders to sustain evidence-based practice (Stetler, Ritchie, Rycroft-Malone, & Charns, 2014).

1.7.3.2 Leadership strategies, skills and behaviours in health care. Davies et al. (2010) **s**uggested that the most effective leadership strategies were those which helped staff learn to use research findings, and those which created environments conducive to learning. Leadership activities consist of supporting, communicating, influencing change, coaching, evaluating outcome data, and cultivating clinical champions (Davies et al., 2010)**.** The team, with the leader's help, must develop a positive attitude and be encouraged to reflect upon the practices and routines that are embedded into the fabric of the organization. Reflective practice brings to mind the "strengths and weaknesses" of what we do and why we do it (Davies et al., 2010, p.

175). It also helps staff within the organization internalize the new practices. Davies et al. described what a leader needs to do within the area of evidence-based practice and how a leader can do these things. Although, Davies et al. did not use the term facilitation, the skills of leadership appeared to overlap those of facilitation as identified in the PARIHS framework.

Stetler et al. (2014) found that there were three categories of leadership behaviours that were displayed by leaders across all levels of the organization (both formal and informal leaders). These included functional behaviours, strategic behaviours, and cross-cutting behaviours. Inspiring and inducing, involving oneself in innovation sustainability, educating and role modelling, and monitoring evidence-based practice implementation were subthemes of functional behaviour. Strategic leadership behaviours were comprised of planning of evidence-based practice, establishing the culture in relation to the practice, and overcoming issues and problems related to the practice. Cross cutting behaviours were those that ran across the realms of strategic and functional leadership behaviours and included strategic thinking, effective and appropriate communication strategies, and maintaining a learning environment (Stetler et al., 2014). Leadership behaviours did not happen in isolation of each other. They often occurred at the same time, (e.g. a leader role modelling a skill and providing education at the same time) with the goal of achieving outcomes related to sustainability of an innovation. Stetler et al. (2014) concluded that the behaviours that they identified in their study can be likened to those of transformational leadership behaviours in that they are relationship-based and empowering.

There are some research articles that identified certain skills that may be considered leadership skills but are listed as individual factors; for example, supervision, feedback, and communication skills (Bass & Judge, 2010; Pluye et al., 2005). It is interesting that these would be identified as separate sustainability factors because one may assume that supervision, feedback, and appropriate communication would be skills required of a leader who is responsible for staff. Savaya et al. (2008) suggested that leaders should be able to implement a plan of action prior to funding running out, overcome obstacles, recruit champions in the community, and manage the political dynamics at the governmental levels. Interestingly, this study did not support the findings of other researchers who identified program evaluation, organizational stability, and adequate funding as factors leading to program survival (Savaya et al., 2008). This study also did not consistently find a relationship between program survival and the use of volunteers as champions, human resources, or organizational readiness.

1.7.3.3 Leadership strategies, skills and behaviours in LTC homes. In LTC, the study of leadership has expanded over the last decade. This is important as there are several leadership roles depending on the LTC home. The leaders may be the administrator, Director of Care, the RN, the LPN or RPN. It is imperative that leadership be explored within this setting because residents deserve to receive quality care that is not only person-centered but safe and based on evidence-based practice (Bowman & Meyer, 2017). In 2003, McGilton suggested that in order to be supportive, a leader must be empathetic and reliable. To be empathetic, the leader needs to recognize and value the needs of their staff, as well as understand and acknowledge the various viewpoints of their staff when they have concerns. To be reliable, the leader must be accessible to staff when they have concerns related to families and residents. They must also ensure that their staff are not only aware of changes within their workplace, but they must also help the care staff express their anger and frustration related to the challenges of working in LTC.

McGillis Hall et al. (2005) examined the view point of staff and managers related to supportive behaviours used by leaders in LTC and the factors that contribute to these behaviours. Staff identified two categories of supportive behaviours: communication behaviours and role-modeling practical behaviours. Communication behaviours consisted of considerate listening; praise, recognition, and positive reinforcement; and respect and trust. Role-modeling practical behaviours was defined as the supervisor helping staff on the floor with their tasks, teaching and providing training, and advocating for staff as required. In this study, staff felt that the factors that contributed to supportive leadership supervisory behaviours included communication, feedback, knowledge, and autonomy.

Supportive leadership behaviours evolved out of the literature as having a strong influence on sustainability. McGilton, McGillis Hall, Boscart, and Brown (2007) examined the role of the DOC in relation to job stress and satisfaction of LTC nurse supervisors. They found that supportive leadership at every level is required to increase job satisfaction and decrease stress. Skills required of the DOC to support their staff included empathy, dependability, and the ability to connect with staff. Given that many RNs, LPNS, and RPNs are in a supervisory role with very little training, the DOC must mentor their supervisors, communicate, and establish positive relationships with them and provide moral support when needed (particularly in difficult situations). McGilton et al. found that “DOC’s practices should be oriented towards relationship-enhancing activities because of the positive effects on supervisor’s perceptions of job

satisfaction" (p. 64). Similarly, Lundgren, Ernsth-Bravell, and Kåreholt (2016) identified that nursing aides who viewed their formal leaders as supportive, empowering, encouraging, and appreciative felt that the psychosocial environment of the nursing home was more positive as compared to homes with leaders who were not supportive.

Boström, Kajermo, Nordström, and Wallin (2009) noted in their study the importance for staff members to have the support of their leaders when using current research in their practice. Leaders must look at strategies to engage care staff in using research in their daily practice and RNs and DOCs need be trained to lead, facilitate, and think critically, so that they may work with team members to provide care that is individualized and relationship based (McGilton et al., 2016; McKinney, Corazzini, Anderson, Sloane, & Castle, 2016). Janes et al. (2009) and McKinney et al. (2016) suggested that leadership is an important contextual factor for the successful implementation of evidence into practice. They suggested that leaders need to work on flattening the hierarchical structures within the culture of LTC and strive to create ways in which care staff can collaborate and work with management to improve resident outcomes.

Additional characteristics identified in the literature related to supportive and relational leadership skills included dependability, respecting uniqueness, and developing and maintaining strong positive working relationships with staff (McGilton, 2010). It is important for supervisors to respect the staff who work with the residents in LTC homes and to express gratitude for a difficult and challenging job. "By using these supportive behaviours, it is possible that a culture of blame that exists in LTC facilities may be replaced by a focus of listening to each other's point of view, with the aim of improving care" (McGilton, 2010, p. 229).

To further develop leadership in relation to person-centered care in LTC homes, Lynch, McCance, McCormack, and Brown (2018) evaluated the impact of the Person-Centered Situational Leadership Framework. Within this framework, situational leadership occurs when a leader evaluates the performance, buy in, and ability of individuals to complete person-centered care for residents within their LTC homes. Based on this appraisal, the leader changes their approach to reflect the stage of the employee (called learner; Lynch et al., 2018). There are seven characteristics that Lynch et al. (2018) labelled as key factors of leadership that assists in developing person-centeredness in staff: understanding the relationship of being a leader, acting in conjunction with the values of the organization, navigating the balance between regulations and person-centered care, motivating others to act, listening from the heart, connecting in the

moment, and establishing trust and a collaborative relationship. The heart of this framework lies in the relationship between the leader and the individual providing care to residents in LTC homes. The situational leader works with the employee to move beyond simply working within a LTC home, and connecting in the moment so that person-centered care can be completed on a daily basis (Lynch et al., 2018).

The PARIHS framework was used by Øye, Mekki, Jacobsen, and Førland (2016) to analyze how the sub-element of leadership influences practice change (restraint reduction) in four LTC homes in Norway. This study found that the role of leadership (as well as the skills and attributes) is not a sole position, isolated from the organization, but one that is collaborative and social in nature. This is a similar position as those cited by Corazzini et al. (2015) and Harvey and Kitson (2015a) who described leadership as a "humanistic" process. Øye et al. concluded that leadership should not be viewed on a continuum of low to high as expressed in the PARIHS framework, but as a process that is complex, based on a multitude of skills, and conducted by many individuals across the spectrum of the organization. A surprising result of this study is that they found that a leader who is not always involved in the daily happenings of the evidence-based practice was successful in implementing the innovation. Minimally, a leader is required to "facilitate the internal knowledge utilization process" in relation to the innovation being implemented (Øye et al., 2016, p. 753).

There is a link between leadership and sustainability of evidence-based practice. The literature above on sustainability indicates that leadership plays an important part in the sustainability of programs or innovations. Leadership is also recognized within the PARIHS framework as a sub-element of context. This sub-element must be examined within the current study because it may impact the sustainability of the GPA program within the LTC homes. Yin (2009) suggests that rival theories should be identified prior to the data collection within-case studies. For this reason, leadership is being built into this study so that the relationship between leadership and sustainability can be examined and explored with respect to an educational program particularly in LTC homes.

1.8 Summary

In summary, there are a multitude of factors that have been proposed as predictors of sustainability, with little agreement on which factors are most important. As proposed in the PARIHS framework, high facilitation occurs when appropriate facilitation is present, where

"appropriate" may include a range of roles and interventions depending on the needs of the particular situation (Rycroft-Malone, 2004). More research is needed to build our understanding of the types of facilitation needed to support staff in LTC homes in sustained practice change following an educational intervention. In the literature related to facilitation and sustainability, there is mention of a role in which an individual is helping, leading, facilitating, championing, or advocating. Different terms are used in different areas of the research discussed in the facilitation and sustainability sections. The term program champion is used interchangeably with leader, program advocate, and facilitator. Each of these individuals, regardless of the term used to describe their role, is focussed on changing practice. The PARIHS framework identifies transformational leadership as one of the sub-elements of context that is associated with research utilization and the i-PARIHS framework speaks to humanistic and inclusive leadership across the organization. However, given the fact that there is overlap between facilitation and leadership, this research explored the relative influences of leadership (Paper 1) and facilitation (Paper 2) in relation to sustainability.

CHAPTER 2.0 METHODS

2.1 Research Problem and Questions

The i-PARIHS framework identified facilitation as a key factor in the implementation and sustainability of best practice interventions in health care settings (Harvey & Kitson, 2015). However, little is known about which dimensions of facilitation in LTC are most important or how they operate. Additionally, we do not know how facilitation interacts with other factors identified in the i-PARIHS framework that may influence sustainability of research evidence. The purpose of this research was to examine the relationship between facilitation, leadership, and the sustainability of best practice guidelines in rural LTC homes, with a particular focus on an educational intervention for staff aimed at management of responsive behaviours (Gentle Persuasive Approaches Program [GPA]). This study examined the short term sustainability of the GPA program as the time frame was 15 months from program installation (Stage 2 of the implementation process; Fixsen et al., 2005) to end of data collection. The GPA program was considered fully installed into the LTC homes when all resources (i.e., selection and training of the GPA Coaches, funding to provide the GPA program to all staff in the LTC home, and space to hold the training) were secured and all staff were trained in the 7.5 hours GPA program. Although the GPA program does not have a formal facilitator role and many rural LTC homes do not have the resources for a specific facilitator position, the implementation of the GPA program provided an opportunity to gain an insight into facilitation within the i-PARIHS framework and how it relates to sustainability of a dementia-specific training program. Specifically, this study explored who was doing facilitation, how they did it, what facilitation activities occurred in the rural LTC homes, and how these factors influenced sustainability. The role of leadership in sustainability was also explored.

As noted earlier, the assumption behind the i-PARIHS framework is that the "successful implementation results from the facilitation of an innovation with the recipients in their inner and outer context" (Harvey & Kitson, 2015b, p. 40). The *general proposition* that guided this research was that *facilitation plays an important role in the sustainability of best practice interventions such as the GPA program*. The rival explanation that was considered during this

research was that *leadership rather than facilitation leads to the sustainability of evidence-based practice.*

To maximize the opportunity provided by the adoption of the GPA program by a large health region on the Canadian Prairies, this research project was conducted using a *retrospective study* in five rural LTC homes in which the GPA program had already been fully installed (Fixsen et al., 2005) and a *prospective study* that began with the program installation (Fixsen et al., 2005) of the GPA program in two rural care homes and followed events over a 15 month period. The two studies provided two viewpoints (looking back and looking ahead) on the relationship between facilitation and sustainability.

Questions that were examined in both studies were:

1. What is the relationship between facilitation and sustainability of training programs in rural LTC homes? What roles, skills, and attributes of facilitators are associated with sustainability?
2. In what ways do the internal GPA Coaches act as facilitators during and after program implementation? How do the facilitation activities of the internal GPA Coaches compare to others who may play a facilitation role?
3. What is the role of leadership in sustainability of the GPA program?

2.2 Case Study Method

Case studies are an excellent way to understand complex social phenomena (Yin, 2014). This method of research allows an individual the opportunity to preserve meaningful information and characteristics about real life scenarios such as organizational change, small group dynamics, or individual relationships (Yin, 2014). Case studies are useful when a researcher is trying to understand how or why a certain event or relationship exists, does not have control over behavioural events, or is studying a contemporary event (Yin, 2014). This method was a good fit with the opportunity provided by the gradual installation of the GPA intervention across rural LTC homes in the health region.

Yin (2014) asserted that the case study method is different from other research methods because the researcher is able to study real life, complex events by using multiple data collection methods (which are used to triangulate the data) and data analysis strategies and approaches (i.e., theoretical propositions and rival explanations) to gain an in depth understanding of the phenomenon or context being studied. Case study research has evolved since the 1980s to be

more than a data collection tool or a design logic, but a strong, stand-alone research method (Yin, 1984).

An important step within the case study method is to define the unit of analysis (Yin, 2014). In order to do this, there are two issues that must be addressed. The first is to define the case as it is related to the research questions and the second is to establish the boundaries of the case (Yin, 2014, p. 34). Given that this current research examined the relationship between facilitation and sustainability of a dementia-specific training program in rural LTC homes, a *case* was defined as an LTC home. "Bounding the case" (Yin, 2014, p. 33) was done in relation to the research questions by selecting only the rural homes in a large predominantly urban health region where the GPA program installation was mandated.

Selection of the boundaries is important within a case study because they allow the researcher to distinguish between the data collected related to the topic at hand versus the data from the external context (Yin, 2014). To examine the research questions here, LTC homes (cases) in rural settings were distinguished from care homes in urban settings (external context) within the same health region. The boundaries of a case may include: the individuals being studied, geographical areas, or units of time (Yin, 2014). The unit of analysis for this research project addressed all three of these issues by including staff from all rural LTC homes that had fully installed (Fixsen et al., 2005) the GPA program one year prior to the start of the study (the retrospective study) and those homes that began installation at the start of the study (the prospective study).

There are four types of designs for case study research. These include single or multiple case designs with either holistic or embedded units of analysis (Yin, 2014). Yin (2014) has argued that the evidence derived from using a multiple-case study design is often more "compelling support" (p. 57) for propositions than single case studies, but the multiple-case study approach is more expensive, time consuming, and may not be feasible. When a multiple-case study research design is used, it is important that the sites are selected using a replication logic and not based on sampling logic, such as used in survey research (Yin, 2014). Using replication logic, each case is selected using matching or replication based on specific selection criteria (*literal replication*) or selected for their different characteristics (*theoretical replication*) (Fitzgerald & Dopson, 2009; Yin, 2014). The goal of replication logic is to build a stronger framework to identify the conditions under which the phenomena being studied occur and when

they do not (Yin, 2014). Replication logic enables generalization. The more cases selected that either support the research questions or the rival explanations, the stronger the theory that can be built. In the current study, replication logic facilitates the detection of relationships between facilitation, leadership, and sustainability of programs or innovations in LTC homes. In the multiple-case study design approach, each single case is considered as a "whole," in which several data collection methods are used to provide evidence that converges to strengthen the findings within the case. In this multiple-case design, there were seven single cases: five retrospective and two prospective. The retrospective cases were selected using literal replication (matched on specific inclusion criteria) and prospective cases were selected using theoretical replication (based on differences in the cases that could assist in detecting relationships between facilitation and sustainability; Fitzgerald & Dopson, 2009; Yin, 2014). More detail about site selection is provided in the method sections of the retrospective and prospective studies.

The unit of analysis for single and multiple-case designs may be either holistic or embedded in nature (Yin, 2014). An embedded unit of analysis is where the researcher is interested in studying smaller subunits within the overall context (Yin, 2014). For example, if a study was about a particular phenomenon occurring within a hospital, the researcher may examine smaller areas within the organization like the surgery ward or the human resources department. A holistic design is used when the global nature of a phenomenon or program are being studied (Yin, 2014).

Within the present research project, an explanatory, holistic, multiple-case study design (seven cases) was used to study the relationship between the concepts of facilitation and sustainability of the GPA program, and between leadership and sustainability of the GPA program. Yin refers to the "iterative nature of explanation building" (2014, p. 149) which was achieved here by examining the research questions retrospectively (five homes had already installed the GPA program) and prospectively (two contrasting homes were followed over time during the installation period). These studies were designed to take advantage of the strengths of a case study design as it used several methods of data collection, theoretical propositions, rival explanations, and a comprehensive data analysis framework that will be discussed further in this chapter. The two studies were conducted concurrently.

2.3 The Researcher

The researcher is a registered Social Worker, licensed within Canada for almost two decades. Most of her career has been spent in health care, particularly working in the field of geriatrics. At the time of this research study, the researcher was employed as a behavioural consultant for several LTC homes within a large health region on the Canadian Prairies. The researcher was employed by the same health region (not the individual LTC homes) in which this project was conducted. In conjunction with other behavioural consultants, the researcher completed assessments of residents living in LTC homes who were displaying responsive behaviours. Prior to the start of the study, the researcher had completed, as a behavioural consultant, assessments in 27 of the 30 care homes in the health region. The overall goal of this position was to improve the quality of life for residents in the care home by teaching staff about dementia, responsive behaviours, and personalized care. The behavioral consultants made recommendations based on the information that was gathered about residents through chart reviews, meeting with staff, spending time with the residents, and talking with their family members. All of the assessments and recommendations were based on person-centered care and were resident specific. Follow up was provided after initial assessments and the behavioural consultants worked with staff to assist them in finding ways to meet the needs of the residents within the care home. The researcher did not complete any behavioural assessments in the seven homes during the current research.

When the researcher was hired within the health region in 2007 as a behavioural consultant, she was asked to make a recommendation to Senior Leadership regarding a training program that would help staff in care homes manage responsive behaviours. The researcher conducted a literature review that identified elements that have been recommended for inclusion in a behavioural management course for staff in care homes (Danylyshen-Laycock, 2009). The curriculum of ten behavioural management programs were compared against these criteria. The Gentle Persuasive Approaches Program was recommended to Senior Leadership because it met all 13 criteria recommended in the literature. The researcher attended the GPA Coach training in September 2007 and began to teach the curriculum in three of the care homes in the health region. These three homes were not a part of the current research project. The researcher became a Master Coach in April 2010 and was responsible for implementing and evaluating the GPA program in all 30 of the care homes within the health region. In addition, she was in charge of

training all the GPA Coaches across the province. One of the responsibilities of the Master Coach was to attend the first training session given by each of the GPA Coaches when they returned to their care homes following their two-day training program. The researcher attended the initial training session in approximately one-third of the care homes in the health region.

The researcher was aware of the fact that she had spent time in each of the care homes either as a behavioural consultant, GPA Master Coach, or GPA Coach. In the homes for the retrospective study, the researcher had completed only one behavioural assessment in each of four LTC homes in the previous four years prior to the installation of the GPA program. The researcher had never been consulted to provide a behavioural assessment in the fifth care home of the retrospective study. As the GPA Master Coach, the researcher trained the GPA Coaches for all five of these homes and attended the initial training session of the GPA Coach in one of the five homes selected. With respect to the prospective study, the researcher completed only one assessment as a behavioural consultant in each of the two care homes in the four years prior to the start of this study. Another GPA Master Coach attended the initial training of the GPA Coaches in the two prospective study homes. The role of GPA Master Coach was consistent across these two care homes.

In both of these prior roles (consultant & educator), the researcher established relationships with all of the managers/administrators/directors of care (DOC) through the behavioural assessments and the coordination of the GPA program. There was potential for staff to see the researcher in a role of influence as the behavioural consultant or GPA Master Coach, but this potential was equivalent across all the seven care homes selected for the research project. Given that the researcher had previous relationships (to differing degrees) with the staff in the homes selected for the research, many of the participants were already comfortable with and trusted the researcher. There were no participants who declined to be a part of this study as a result of a pre-existing relationship.

Two GPA Coaches, the Clinical Nurse Leader (CNL) in the prospective study, and two nursing aides (NAs) did approach the researcher looking for help and guidance in situations in which they were working with residents with responsive behaviours. The researcher responded briefly to the staff questions but did not initiate these interactions. All conversations were documented in the field journal and the researcher monitored and evaluated the effects that occurred as a result of these interactions. The researcher felt that if she did not provide staff with

the assistance that they were looking for, it would negatively impact the relationship that she had within the home and ultimately the data that were being collected. When the staff within the care home were requesting assistance with behavioural issues that were more complex in nature, the researcher referred them to other behavioural consultants for follow up.

2.4 Retrospective and Prospective Study Methods

The gradual installation of the GPA program in 30 urban and rural LTC homes in a single health region provided an opportunity to examine the i-PARIHS elements of facilitation and leadership and how they are associated with sustainability in homes where the program had already been fully installed (Fixsen et al., 2005; retrospective study), and those where the GPA program was being installed at the start of this research project (prospective study).

2.4.1 Retrospective Study Methods

A retrospective qualitative multiple-case study research design was used for this study. The selected design logic for the retrospective study was matching or replication of multiple cases (literal replication; Fitzgerald & Dopson, 2009). The study was cross-sectional in that data were collected at one point in time (post GPA installation) within five rural LTC homes. Participants were asked to look back retrospectively on their experiences in the past 12 to15 months since installation of the GPA program.

2.4.1.1 Site selection. Sixteen of 30 homes in the health region were located outside of a large urban population centre (population of 100,000 and over; Statistics Canada, 2017b). At the start of data collection, there were five rural homes where GPA had been fully installed (Fixsen et al., 2005) and they were all selected for the retrospective study based on replication logic and the proposition that there would be a relationship between facilitation of the GPA installation and sustainability of the program. Fitzgerald and Dopson (2009, p. 472) suggest that matching or replication designs are useful "to explore or verify ideas." Within this design logic, cases are selected according to criteria that are carefully identified prior to data collection (Fitzgerald & Dopson, 2009). Given the dynamic nature of health care, it is impossible to match cases for identical replication. Therefore, the researcher must "select the closest matches and transparently highlight differences" (Fitzgerald & Dopson, 2009, p. 473). Inclusion criteria for this study were (a) GPA fully installed, and (b) located in a rural area or small population centres (see definition below). Based on the researcher's prior knowledge of the five homes, it was expected that the degree to which the GPA program had been sustained across these homes would vary, and that

this variation would help to shed light on the factors associated with continued use (or not) of the program over time.

The five homes in the retrospective study had approximately the same number of residents living in each home, with a range from 17 to 39 (see Table 2.1). They varied in distances away from the urban centre (between 30 – 200 kms). According to Statistics Canada (2017b), a small population centre has "a population of at least 1,000 – 29,999. All areas outside of population centers are classified as rural (i.e., less than 1,000 people)" (para. 1). Three homes met the Statistics Canada definition of being a small population centre and two were classified as rural. The three homes that were classified as being small population centres were included within this study because they had access to fewer resources (e.g., geriatric psychiatry services) than homes located within the large urban population centre and were treated as rural by the health region. By having access to fewer services, staff in LTC homes have limited exposure to mentoring, coaching, and support in identifying and managing responsive behaviours by people living with dementia. Four of the homes within this study were owned by independent boards and one was owned by the health region. Independent homes reported to both a Board of Directors and to the health region while the owned and operated homes reported only to the health region. GPA training for three of the five homes began in May 2010 and training for the other two homes began in October and December 2010 (Table 2.1).

2.4.1.1.1 ***Home 1 Description.*** Home 1 is located in a rural town at the time of this study and is owned and operated by the health region. It was built in the earlier part of the 1970s and has not been renovated to meet the needs of people with dementia. When a person enters the front door of the nursing home, they are standing in a small foyer. To the right of the foyer is a long hallway of resident rooms. The hallways, which are long and narrow, are painted white, while the flooring is a grey tile. Most sounds reverberate in these corridors (e.g., floor polisher, medicine cart, and staff talking to each other). There are fluorescent lights throughout the building which make it difficult for staff to dim the lights when residents are trying to sleep. Resident rooms are small and the walls lack sound-proofing. Several residents must share bathrooms within this home. To the left of the foyer, is a large open area that has been divided into a dining area, sitting area, kitchen, and nursing station. For most of the day, this is the busiest part of the home. Residents congregate here to eat, visit, watch television, and meet with family and friends. This is the only area that the residents have to exercise or wander when they

are agitated. The noise and the stimulation increases in this area during meal times, medication pass, activities, or when the nursing staff are answering phones, charting, or visiting. In addition to these noises, the nurse call system is one where all bells and pages are heard over head. Behind the main visiting and eating area, are two main administration offices. This area is cordoned off from the main area with a steel door. Parallel to the administration office and off the nursing station is another long hallway of resident rooms. In this hallway, staff must store all lifts, laundry carts, and dirty linen baskets because there is no storage space in this building. It is very difficult (and potentially dangerous) for the residents to navigate within this area. At the very end of this hallway is another door that leads to an unfenced visiting area outside. Residents are only allowed out if they have someone supervising them because the nursing home is located on one of the main streets in the town. Staffing levels at this home are similar to many others within the health region. During the day shift, there are four NAs (nursing aides) (who work 8 hours shifts), one nurse (who works 12 hour shifts), and the CNL (week-days) in addition to the manager (week-days). During the evening shift, there are four NAs and one nurse, while at night there are two NAs and one nurse. The ratio of NAs to residents on day shift was approximately 1:10.

2.4.1.1.2 ***Home 2 Description.*** Home 2 is located in a small population centre and was built in the late 1960s to meet the needs of the aging population within this area. There are 31 LTC rooms (Table 2.1) and 20 assisted living suites available. The main entrance into this home is located at the front of the dining room/activity area. The entrance door is steel with no windows. It is difficult to tell that this is the main entrance as the door and the entrance are painted in bland colors and there is no natural light in this area. The ceilings are low in the main dining room and there is very little natural light. The windows to the outside are small and there are large shrubs planted in front of them blocking the view of the street. In one corner there is a small seating area with a large TV. This television remains on for a large portion of the day. In the opposite corner from the seating area is a small curtained off area where the staff eat their meals and have their breaks. It is possible to hear the staff talking to each other when they are sitting in this area. Opposite from the main entrance is the nursing station and the medication room. In order to call for staff, residents and visitors must ring a bell until someone in the home hears it. The overhead paging system and call bell lights can also be heard throughout the building. Between the front entrance and the nursing station, a door to the seniors' assisted living

suites is located. This door is closed at all times. Several residents from the home will pound on this door during the day looking for a way outside. As in Home 1, this main area tends to be loud. Twice a day, recreation activities are held in this room. Activities include children's choirs, country and western singers, hymn services, and bingo games.

To the right of the nursing station is a hallway to the resident rooms. The hallways are narrow and are used to store equipment and laundry. The rooms are small with large windows. Many residents are not able to look outside, as the shrubs planted in front of them have blocked the view. Further to the right of the nursing station is another hallway of resident rooms. At the very end of this corridor is the chapel, administration offices, and the door to the outside courtyard. The chapel is used by the community and the residents living in the assisted living suites. These individuals must travel through the main dining area (adding more noise and stimulation) to gain access to the chapel. The outdoor courtyard is enclosed by a large fence. Within this space, there is a gazebo, garden, and barbeques for families to use when they are visiting. Residents are allowed to go outside on their own if they are able to walk independently. It is difficult to get groups of residents outside for larger events because there is only one Recreation Therapist (RT) and she must porter residents on her own. By the time she brings residents outside, she has very little time to spend with them engaged in meaningful activities. Staffing levels for the care staff are identical to those of Home 1. The difference in this home is that they do not have a CNL or a full time DOC or assistant DOC. Staffing ratios for NAs to residents was approximately 1:10 on the day shift.

2.4.1.1.3 ***Home 3 Description.*** Home 3 was built in the 1980s on private property outside of a small rural town. The home is nestled in a forested area that directly overlooks a small lake. Half of the resident rooms have a view of the lake, while the other half look at the garden or the forest. In addition to the 36 LTC beds (Table 2.1), there are 41 assisted living suites (attached to the home), and 22 independent housing units located directly on the LTC home property. At the main entrance to the care home is a large foyer where residents and visitors may hang up their jackets and sit down to take off their shoes. To the right of the foyer is the dining area. All staff and residents eat in the same area. Staff do not take their breaks in a separate area away from the residents and the residents are free to join the staff at any time. Further down the hallway, past the dining area, are the nursing station and the administration offices. This area is the "hub" of the nursing home. Three hallways of resident rooms branch off from the area surrounding the

nursing desk. The hallways are wider and have been each painted a separate color so that the residents may be able to tell which hallway their room is down. There is a "family visiting area" located down each hallway. This makes it easier for residents who are looking for privacy or quiet spaces to escape louder areas/residents within the building. Resident rooms are bigger than those in many of the homes within the health region. The windows are large and allow plenty of natural light into the rooms. Each room has a unique view of a natural setting (e.g., lake, forest, or garden). There are more storage areas in this building. Unfortunately, the larger lifts and linen carts are kept in the hallway which makes walking and transporting residents in wheelchairs more difficult.

Unlike Homes 1 and 2, Home 3 has a separate enclosed indoor area for residents to exercise and participate in group activities. This room decreases the amount of noise that can be heard throughout the building. The nurse call system is similar to those in Homes 1 and 2 where call bells and overhead pages are heard throughout the building. At the back of this LTC home, there is a large fenced area where residents who are physically able to mobilize on their own are allowed to go outside. The RT has an additional staff member on during the day to help her with activities and porter staff so that more residents are able to go outside, or participate in activities inside the home. Staff ratios are somewhat higher during the day in this LTC home. There is one RN (who works 12 hour shifts) and five NAs (who work 8 hour shifts) during the day. On the evening shift there is one nurse and three NAs. During the night shift, there is one nurse and two NAs. The home has a full-time administrator and a part time DOC. Staffing ratios for NAs to residents on day shift was approximately 1:7.

2.4.1.1.4 ***Home 4 Description.*** Home 4 is located in a small population centre. It was built in the late 1990s and is the newest of all of the homes in this study. The design layout is very similar to that of Home 3. The only difference to the design is that the dining room is on the opposite side of the hallway and that the administration offices are at the main entrance. The home has three corridors of resident rooms, private visiting spaces down each hallway, and a separate activity space in the same area as in Home 3. The staff break area/lunch room is at the end of the middle corridor. It has a locking door on it so that residents are not able to enter. The corridors are not painted different colors and residents often get confused trying to locate their room. Resident rooms have large windows and a view of the back courtyard area. This outdoor space is fenced in so that residents are able to go outside when the weather is nice. Typically,

only the individuals who mobilize independently are able to go into the courtyard area on their own. There is one full time RT who often has volunteers to help run larger group activities. The staffing levels in this home are the same as those in Home 2. There is a full-time administrator and a full time DOC. Staffing levels on day shift for NAs to residents was 1:10.

2.4.1.1.5 ***Home 5 Description.*** Home 5 was built in the early 1950s in a small population centre. Within this building, there are 17 LTC beds and 11 assisted living suites. The home has a very small foyer that leads to the nursing station and resident rooms on the right and the dining room/kitchen/activity area on the left. Similar to other older buildings in this study, this LTC has a combined dining/recreational area which can be very loud and over stimulating for residents with dementia. Staff eat all of their meals within the dining area and residents will often join them at the tables. The dining area has been decorated to reflect restaurants or kitchens in the 1950's (e.g. chrome tables and chairs, plastic red and white table cloths, doilies on the furniture, white counter spaces and large plush chairs). There are no private visiting spaces for families or residents within this home. The rooms are similar to those in Home 2 and the hallway is narrow and cluttered with equipment and laundry carts. There is no RT employed within this home. The administrator is responsible for booking volunteers and musical groups to entertain the residents. NAs will often help with recreation activities because there is no one else who is able to do it. Given that the home is located on a busier street and does not have any fenced in areas for residents to go outside, residents must wait for a family member, volunteer, or staff member to take them outside. Staffing levels within this home are the highest within this study. There are four NAs and one nurse who work 12 hour shifts on day. There are two NAs and no nurse coverage at night. If staff members need assistance from an RN, they must call the DOC (who is the RN who works during the day) and she will come back to the nursing home. The DOC and administrator are employed part time in this home. The staffing ratio of NAs to residents during the day shift was 1:4.

Table 2.1

Comparison of Rural LTC Home Characteristics in the Retrospective Study

Rural LTC Home	Ownership and Reporting Structure	Formal Leadership Team and Employment Status	Number of LTC Beds	Staff on Day Shift (M-F)	Start Date of GPA Installation	Position of GPA Coaches
Home 1	Health Region Owned and Operated (report to Health Region)	Manager (F/T)	39	Nurse, NAs, CNL, Manager, RT	December 2010	NAs
Home 2	Independently Owned (report to Board and Health Region)	Administrator (F/T) DOC (P/T)	31	Nurse, NAs, Administrator, DOC, RT	May 2010	RN and NA
Home 3	Independently Owned (report to Board and Health Region)	Administrator (F/T) DOC (P/T)	36	Nurse, NAs, Administrator, DOC, RT	May 2010	RN and NA
Home 4	Independently Owned (report to Board and Health Region)	Administrator (F/T) DOC (F/T)	36	Nurse, NAs, Administrator, DOC, RT	May 2010	RT and NA
Home 5	Independently Owned (report to Board and Health Region)	Administrator (P/T) DOC (P/T)	17	Administrator, DOC/RN, NAs	Oct 2010	NAs

Note. Director of Care = DOC. Clinical Nurse Leader = CNL. Registered Nurse = RN. Nursing Aides = NAs. Recreation Therapist = RT. Direct Care Staff included CNL, Nurses, NAs, RTs, and GPA Coaches. Formal Leaders included Administrators, Managers, and Director of Care. F/T = Full Time. P/T = Part Time

2.4.1.2 Participants. The retrospective study focused on the experiences of the administrators (*n*=3), DOCs (*n*=2), managers (*n*=1), CNL (*n*=1), GPA Coaches (*n*=5), RNs (*n*=3), and NAs (*n*=16) during and after the implementation of the GPA program in their care homes. The formal roles of administrator and DOC existed only in the independently owned homes. The administrators were responsible for the business side of the LTC home (e.g., budgets, maintenance issues, supervision of other managers), and the clinical decisions (e.g., staffing of the nurses, NAs, and resident care issues) within the LTC homes were made by the DOC (who reports to the administrator). The formal role of manager is a position that exists only in the homes that are owned and operated by the health region. The manager is responsible for making both clinical and operational decisions within the LTC home. This role is filled by a RN or a Licenced Practical Nurse (LPN).

A Clinical Nurse Leader (CNL) is defined as a RN who acts as a case manager for the residents and is the main contact for family members and physicians if there are medical or clinical issues, or responsive behaviours displayed by the resident. The person in this position is also responsible for mentoring and providing leadership to all employees involved in resident care and assessments. They provide education as required to other nurses and NAs, manage staff conflict, and mitigate risks to staff and residents as required. The CNL reports to the manager of the home and may be required to provide day-to-day direction to staff regarding nursing services if a manager is not available.

GPA Coaches were individuals who had attended and successfully completed the two-day GPA training course taught by the GPA Master Coaches. These individuals were then responsible for providing the one-day GPA course to all staff within their LTC home. The GPA Coaches in this study included RNs, NAs, and RTs. Nurses were defined as those individuals who were responsible for the medical care of the residents and NAs were those individuals who provide the hands-on care daily care. Ancillary staff (i.e., kitchen workers, housekeepers, environmental services, ward clerks, receptionists, and schedulers) were not interviewed due to feasibility issues (i.e., time constraints for data collection) and the fact that the study focused on factors that influence the ability of direct care staff to use best practices when working with residents with dementia.

2.4.1.3 Ethics. Attendance in the focus groups and semi-structured interviews was voluntary. Nursing staff were approached by the researcher while she was at the home during the

scheduled visit, to complete a 30 to 60 minute interview during that visit in the home. The focus group was arranged ahead of time through the Director of Care (see Data Collection/Procedures section below and Appendices A and B). The researcher provided each participant in the interviews and focus groups with the Consent to Participate in a Research Study form (Appendix C) and reviewed it with each person. The researcher read the consent form out loud for individuals if they requested (i.e., not having English as a first language). Anonymity and confidentiality were discussed with the participants prior to the start of the focus group and semi-structured interviews. All individuals were advised that their employment would not be in jeopardy if they did not participate and that they were free to withdraw at any time. Participants received a five-dollar gift certificate for a local coffee shop for participating in the semi-structured interviews and focus groups.

2.4.1.4 Data collection/procedures. A summary of the retrospective study data collection procedures, role of participants, and number of participants is provided in Table 2.2. Data collection for the retrospective study began in February 2012 and was completed at the end of January 2013. The researcher spent approximately two days every two months in each home collecting data using semi-structured interviews (Gochros, 2005) with managers, DOCs, administrators, a CNL, nurses, and GPA Coaches. Focus groups (Marshall & Rossman, 2011) were conducted with NAs. The manager/DOC/administrator was contacted via email prior to the data collection phase to schedule dates and times for their interviews and focus groups. An information poster (Appendices A and B) was sent to each home approximately two weeks prior to the scheduled date of the site visit inviting staff to participate in the study. GPA Coaches were contacted by email to schedule their interviews. All interviews and focus groups were audio-taped and transcribed by the researcher. The data from each home were analyzed prior to entering the next LTC home.

2.4.1.4.1 *Semi-structured interviews.* For the retrospective and prospective studies, administrators, managers, and DOCs were classified as "formal leaders." Their interviews in this study were grouped together to explore their perspectives of factors that influenced sustainability of the GPA program. GPA Coaches were interviewed to learn about their experiences as Coaches and their perspectives on factors associated with sustainability of the program. Nurses and the CNL were also interviewed to discuss whether they felt the GPA program was sustained in their LTC homes, the impact the training had on the staff they supervise, and the role of

facilitation in sustainability. The focus group interview guide was used with the NA in Home 4 to learn about the barriers and facilitators to using GPA skills in resident care. See Appendix D for the semi-structured interviews and focus group guides. The interview guides were modified iteratively over time as the interviews were conducted to gain an understanding of (a) the philosophy of care within the home (task focused or person-centered); (b) the ability of staff to identify, develop, and communicate care plans to help minimize responsive behaviours; (c) the balance of power between and across employee groups in each home; and (d) the roles, skills, and attributes of individuals who were using the GPA skills in their daily practice.

In Home 1, four semi-structured interviews (*n*=4) were completed, one with a GPA Coach, one with the manager, one with an RN, and one with the CNL (telephone interview). The CNL in this study was an RN. In Home 2, three semi-structured interviews (*n*=3) were completed with the administrator, a GPA Coach, and an RN. In Home 3, two semi-structured interviews (*n*=2) were completed with the DOC and the two GPA Coaches (interviewed together). In Home 4, five semi-structured interviews (*n*=5) were completed with the administrator and DOC (interviewed together), one RN, one GPA Coach, one RT (telephone interview) and one NA. An NA from Home 4 was interviewed as she was the only person who attended the focus group. In the last home (Home 5), only the administrator was interviewed. The DOC (who is also the regular floor RN) participated in the focus group, and the GPA Coaches were not available for interviews.

2.4.1.4.2 *Focus groups*. Focus groups were held in four of the five homes within the retrospective study to maximize the number of NAs who were able to participate in each home. Three NAs (*n*=3) participated in the focus group in Home 1. Three NAs (*n*=3) participated in the focus group in Home 2, and four NAs (*n*=4) participated in the focus group in Home 3. A focus group was not held in Home 4 as the leadership cancelled twice due to other priorities (i.e., health region training and having to work short staffed). A third date was set but only one NA participated. She was interviewed using the focus group interview guide. Finally, a focus group was conducted in Home 5 where four NAs (*n*=4) and the DOC (also the regular RN on the floor) (*n*=1) participated. Appendix D was used to guide the focus groups in the four homes.

The aim of the focus groups was to learn about the experiences of direct care staff with respect to the GPA program and to explore how facilitation could contribute to their ability to apply the knowledge gained from the training over the long-term. As the focus groups were

conducted, questions were added to the interview guide as participants identified additional factors that impacted the implementation and sustainability of the GPA program. Questions were added to gain an understanding of (a) whether or not the NAs would make changes to the GPA program, (b) what additional information care staff felt should be included in the program, and (c) reasons behind staff not charting or reporting a responsive behaviour. Staff were also asked to discuss their views on the philosophy of care within the home, power imbalances and bullying between staff, and whether or not they were able to identify and create a care plan to help manage a responsive behaviour displayed by a resident with dementia.

Table 2.2

Retrospective Study Data Collection Procedures and Participant Roles

Home	Data Collection Procedures	Role of Participants	Number of Participants	Total Number of Participants
Home 1	Semi-structured Interviews	Manager, GPA Coach, RN, CNL	Formal Leaders Interviewed: Manager (*n*=1) Direct Care Staff Interviewed: GPA Coach (*n*=1), RN (*n*=1), CNL (*n*=1)	4
	Focus Group	Direct Care Staff	NAs (*n*=3)	3
Home 2	Semi-structured Interviews	Administrator, GPA Coach, RN	Formal Leaders Interviewed: Administrator (*n*=1) Direct Care Staff Interviewed: GPA Coach (*n*=1), RN (*n*=1)	3
	Focus Group	Direct Care Staff	NAs (*n*=3)	3
Home 3	Semi-structured Interviews	DOC, GPA Coaches	Formal Leaders Interviewed: DOC (*n*=1) Direct Care Staff Interviewed: GPA Coaches (*n*=2)	3
	Focus Group	Direct Care Staff	NAs (*n*=4)	4
Home 4	Semi-structured Interviews	Administrator, DOC, RN, GPA Coach, RT, NA	Formal Leaders Interviewed: Administrator (*n*=1), DOC (*n*=1) Direct Care Staff Interviewed: RN (*n*=1), GPA Coach (*n*=1), RT (*n*=1), NA (*n*=1)	6
Home 5	Semi-structured Interviews	Administrator	Formal Leaders Interviewed: Administrator (*n*=1)	1
	Focus Group	DOC, Direct Care Staff	DOC (*n*=1), NAs (*n*=4)	5
Total				**32**

Note. Director of Care = DOC. Clinical Nurse Leader = CNL. Registered Nurse= RN. Nursing aides = NAs. Recreation Therapist = RT. Direct Care Staff included CNL, Nurses, NAs, RTs, and GPA Coaches. Formal Leaders included Administrators, Managers, and Directors of Care. No focus group was held in Home 4.

2.4.1.5 Data analysis of semi-structured interviews and focus groups. The aim of the retrospective study was to examine the relationship between facilitation and sustainability, as well as the role of leadership in the sustainability of the GPA program in rural LTC homes that had completely installed the program. Although not aimed at developing a theory, since the study was guided by the i-PARIHS framework, the retrospective study was informed by the constructivist approach to grounded theory defined by Charmaz (2006).

2.4.1.5.1 ***Constructivist approach to data analysis.*** In the constructivist approach, analyses are viewed as mutually constructed interpretations as opposed to facts discovered by a neutral expert observer. The data were analyzed using the constant comparative method in which the researcher compares and contrasts the data, the codes that are identified, and then the larger categories in the analysis (Charmaz, 2006). Comparisons are made between incidents within interviews and interviews conducted at different times, or incidents across cases. By doing this, the researcher develops analytic properties within the categories and these categories are continually examined throughout the data analysis phase of the case study (Charmaz, 2006). The analyses were aimed at identifying relationships between facilitation (and leadership) and sustainability of the GPA program.

The first step in analyzing the data was to code the interviews and focus groups by giving the participants' words an interpretive meaning. "Qualitative codes take segments of data apart, name them in concise terms, and propose an analytic handle to develop abstract ideas for interpreting each segment of data" (Charmaz, 2006, p. 45). The researcher ensured that codes were closely connected (grounded) to the data and did not force pre-conceived thoughts or ideas on the data. Charmaz (2006) describes two main phases of coding. Initial codes are provisional in that the researcher stays open to other possibilities that may evolve out of the data. Initial coding allows the researcher to test ideas, identify gaps in the data, and remain open to other factors that may be related to the problem that is being studied. During the initial coding, incident to incident coding comparison was conducted for the semi-structured interviews and the focus groups (Charmaz, 2006). This type of coding allows the researcher to initially examine incident against incident within the interviews and focus groups.

Focused coding is the next step in the analysis process, and involves using the most significant or frequent initial codes to "sort, synthesize, integrate, and organize large amounts of data" (Charmaz, 2006, p.46). Focused coding is more specific in nature and it requires the

researcher to make decisions about the codes that make the most sense in categorizing the data. Focused coding allowed the researcher to check her ideas about the preconceived notions that she may have had about the data. Memo-writing was used to capture the emerging analyses as coding was conducted. These analytic notes helped the researcher to think about the data, and provide a place to document ideas from the constant comparative process (Charmaz, 2006). During the focused coding, the writer compared the codes from each interview against other interviews within each home. For example, the codes of the interviews in Home 1 (GPA Coach, RN, manager, and CNL) were all compared against each other. This allowed the researcher to identify if there were similarities or differences for the various participant groups within each home as it related to facilitation, leadership, and sustainability. Second, the interview codes of each participant group were compared across five homes (i.e., codes from each GPA Coach interview were compared against each other, and each administrator, DOC, and manager were compared against each other across the five homes). Third, the interview codes from each participant group across the five homes were compared across and against each other (i.e., codes from the interviews from the GPA Coaches from all five homes against the codes from all RN interviews). Fourth, the codes from each focus group were compared across and against each other (i.e., the codes from focus group one were compared against focus group two). Finally, the codes from the focus groups were compared against the codes from the participant groups in the interview groups. When focused coding was completed, the number of initial codes had decreased, and it allowed the researcher to "condense the data and provide a handle on them" (Charmaz, 2006, p. 59). Data charts and poster boards were used to visualize the data in order to compare and contrast the differences and similarities across groups, homes, and data collection procedures.

The researcher completed all data analysis for the retrospective study and the prospective study without the use of computer software. As the researcher transcribed all of the interviews and focus groups on her own, she was very comfortable and familiar with working with the paper documents. After transcription by the researcher, all interviews and focus groups were revisited frequently during the coding process. Initial coding was completed prior to conducting interviews and focus groups in the next home.

2.4.1.5.2 ***Within-case and cross-case analysis.*** These analyses will be described in depth after the description of the prospective study. The analysis strategy was consistent across the retrospective and prospective studies.

2.4.2 Prospective Study Methods

In this study, the researcher was able to witness and experience the process related to facilitation and sustainability longitudinally in two rural LTC homes where data collection started two months after GPA was being installed (Fixsen et al., 2005) into the homes (i.e., prospective from the GPA intervention). The prospective study further explored the relationship between facilitation, leadership and sustainability, guided by the research questions outlined earlier. This prospective study was a longitudinal, multiple-case study (two sites), which was based on the comparison of difference design logic, in which purposeful sampling (Fitzgerald & Dopson, 2009) supports the analysis by helping the researcher to focus on differences that facilitate the detection of relationships between variables in the context of each case. Thus, sampling must relate to the research questions under study. The analysis framework for the case study is also linked to the design logic (Fitzgerald & Dopson, 2009). The comparison of difference design logic is consistent with the theoretical replication design logic described by (Yin, 2014) in which each case in multiple-case designs is selected so that it predicts contrasting results for anticipatable reasons. Cases are deliberately selected because they offer contrasting situations.

2.4.2.1 Site Selection. Consistent with the comparison of difference design logic, two homes were purposefully selected from eight homes (where GPA program installation was to begin in 2011) to provide maximum variation on organizational factors that may influence the installation and sustainability of a dementia-specific training program for staff in LTC homes. The two homes (Homes 6 and 7) that were selected for this study were in the same health region as the homes in the retrospective study (see Table 2.3). One LTC home was located in a small population centre, while the other LTC home was classified as being located in a rural area (Statistics Canada, 2017b). Differences in the two LTC homes were: (a) the owner-operator model (independently owned vs. owned and operated by the health region); (b) management and reporting structure (manager vs. an administrator and DOC); (c) the position of the GPA Coach (i.e., NAs versus a LPN and CNL); and (d) presence or absence of a CNL position (defined in Participant section in the retrospective study) in the home.

A key difference in the two homes was the presence of a CNL within the health-region owned and operated homes (Table 2.3). Although not formally described as a facilitator, the role of the CNL encompassed many of the activities associated with facilitation. The presence of the CNL in the health region owned and operated home, and the fact that this person was one of the GPA Coaches (along with an LPN), provided a contrast to the independently owned home, which had no CNL and where the GPA Coaches were NAs. The homes were similar in the number of residents living in them and the distance away from the large urban centre (Table 2.3). GPA training for all staff began in each of these two homes on October 1, 2011. The prospective study was conducted over 15 months in these two rural LTC homes, from the GPA program training through the installation phase (Fixsen et al., 2005).

2.4.2.1.1 ***Home 6 Description.*** Home 6 is a 35 bed LTC home (built in the 1980s) in a small population centre (Table 2.3). The home is joined to the hospital and public health clinic by a large walkway and multi-purpose room. An individual may enter the LTC home from either the hospital side or through the LTC home front door. If a staff member or visitor enters via the hospital, they must walk through a hallway that opens up into the multi-purpose room. On both sides of the link way are double doors that are not secure or alarmed. The multi-purpose room is a large area where residents from the LTC home and the day program gather to visit, play games, and watch TV. There are many long tables for families to sit around and visit, and a piano if someone would like to play, a canary cage for residents to look at, and many shelves that hold plants. It is the sunniest room in the building. The multi-purpose room leads to a long hallway of resident rooms. At the end of this hallway is the nursing station. To the right and left of the nursing station there are two other long hallways that house ten residents per wing. The rooms are large, private, and sunny and residents do not have to share washrooms with each other. The hallways are large and roomy. Due to a limited amount of storage space, the staff must store equipment and laundry supplies in the hallway. On the left side of the nursing station is the dining room, the kitchen, the television room, and the staff lunch room. Directly in front of the nursing station is the staff charting room.

Around the corner from this room is the manager's office (which she uses when she is working on the LTC home side of the building) and the front entry to the home. The manager splits her time between the LTC home and the hospital, so she has another office on the hospital side of the building that she uses when she is scheduled at the hospital. A full time RT is on staff

Monday- Friday from 10:30 – 19:00 to provide residents with activities in the evenings. There is a large enclosed courtyard for the residents to spend time outdoors off the back of the building, and an outside enclosed space in front of the building where residents can go outside (unsupervised) in all seasons (this area can be supervised from the dining room area). Staffing ratios of NAs (12 hour shifts) to residents during the day was 1:7 with a nurse on shift for 12 hours. At night time, there were two NAs and one nurse. The CNL works part time in the LTC home and part time in the hospital (two and a half days per week on each side of the building).

2.4.2.1.2 ***Home 7 Description.*** Home 7 is a 30 bed LTC home that is located on the outskirts of a rural town. The LTC home was built in the 1980s to meet the growing need of the aging population in the rural town. The entrance into the nursing home leads into a large foyer where residents have space to hang their jackets and take off their shoes. Ahead of the front doors is the nursing station and the administrator's office. To the left of the front door is the TV room. This room houses six recliners which face the 42-inch television screen that is mounted on a table. The TV room is connected to the recreational area. There are floor to ceiling windows which cast light (and warmth) on those who are sitting directly in front of them. The recreation area is the part of the building where most of the residents are brought to participate in activities. The only furniture in this room is three long tables that run parallel to the windows. The recreational room opens into the dining room and kitchen. There are six tables within the recreation room. Some of the tables have chairs for residents to sit in, while others are left open for residents in wheelchairs. This area is the nosiest in the entire building. The television is on most of the day and evening, and all of the residents tend to spend most of their time in this area.

The dining room overlooks a fenced in courtyard. Within this space, there is a gazebo and an open patio. Behind the nursing station is the medication room and three hallways of rooms (ten per hallway). At the top of one of the hallways is the tub room and down the other two wings are lounge areas where residents may go with their families to visit or watch TV. Directly to the right of the front door is the DOC's office. Her office has windows that look out into the hallway and at the nursing station. On day shift, there are four NAs (working eight hour shifts) and one nurse who work 12 hour shifts. The staffing ratio during the day for nursing staff to residents was approximately 1:7. In the evening, there were two NAs and a nurse. At night, there were only two NAs in the building, and the RN was on call. A full time RT is employed Monday

to Friday from 8:30- 16:30. She is responsible for coordinating and leading all the resident activities within the home. The administrator and the DOC are employed in part time positions.

Table 2.3

Comparison of Rural LTC Home Characteristics in the Prospective Study

Rural LTC Home	Ownership-Reporting Structure	Formal Leadership Team and Employment Status	Number of LTC Beds	Position of GPA Coaches	Clinical Nurse Leader Present in LTC Home	Date of GPA Installation	Staff on Day Shift (M-F)
Home 6	Health Region Owned and Operated (report to Health Region)	Manager (F/T)	35	CNL and LPN	Yes	Oct-11	Nurse, NAs, RT Manager and CNL split time between LTC home and hospital
Home 7	Independently Owned (report to Board and Health Region)	Administrator (P/T) DOC (P/T)	30	NAs	No	Oct-11	Nurse, NAs Administrator, DOC, RT

Note. Director of Care = DOC. Clinical Nurse Leader = CNL. LPN = Licensed Practical Nurse. Nursing Aides = NAs. Recreation Therapist = RT. Direct Care Staff included CNL, Nurses, NAs, RTs, and GPA Coaches. Formal Leaders included Administrators, Managers, and Director of Care. F/T = Full Time. P/T = Part time.

2.4.2.2 Participants. The prospective study focused on the experiences of staff in all departments from the two LTC homes related to their experiences during the implementation and sustainability of the GPA program. In Home 6, the following staff participated in the semi-structured interviews: manager (*n*=1), CNL (*n*=1), GPA Coach (*n*=1), NA (*n*=1), dietary/administrative support (*n*=1), ward clerk (*n*=1), Recreation Therapist (RT) (*n*=1). Additionally, a NA (*n*=1) agreed to participate in a brief discussion. In Home 7, the following staff participated in the semi-structured interviews: RN (*n*=1), GPA Coaches (*n*=2), NAs (*n*=2), administrative support (*n*=1), RT (*n*=1). Two NAs and the RT participated in brief discussions. There was a change in the DOC position half way through the data collection phase in Home 7. This individual was replaced by a RN from outside the Health Region for the second half of data collection. She did not receive GPA training during the data collection phase but she participated in a brief discussion.

2.4.2.3 Ethics. Two months prior to data collection, the researcher arranged with the manager in Home 6 and the DOC in Home 7 to conduct an information session informing staff about the study. These information sessions were held following a staff meeting approximately one month prior to the start of data collection in both LTC homes. Staff were able to ask the writer questions about the data collection methods that would occur in their LTC homes. All staff who participated in the prospective study were advised that participation was voluntary and that they were able to withdraw at any time without their employment being placed in jeopardy. Individuals who participated in the semi-structured interviews were given a Consent to Participate in a Research Study form (Appendix C) and it was reviewed with each participant. The consent form was read out loud for individuals if they requested it (i.e., not having English as a first language). Anonymity and confidentiality were discussed with the participants who agreed to be interviewed. Participants received a five-dollar gift certificate for a local coffee shop for participating in the semi-structured interviews. Staff members were asked if they could be shadowed or interviewed (formally or informally) by the researcher. They were advised that if they did not feel comfortable with being shadowed or interviewed that they did not have to participate with no risk to their employment status.

2.4.2.4 Data collection. Data collection began in December of 2011 and took place three weeks out of every month (approximately two days per week) and alternated between the two prospective LTC homes. Transcription and data analysis were ongoing throughout the study.

2.4.2.4.1 ***Data collection procedures.*** Case studies are by definition multi-method and inclusive of multiple stakeholder perspectives (Fitzgerald & Dopson, 2009; Yin, 2014). Three data collection strategies were used in this study: document reviews, direct observation, and semi-structured interviews. The researcher began data collection by reviewing documents and observing direct care staff. According to (Charmaz, 2006) "anchoring your data in a solid substantive base first gives you leads about where and how to proceed in other areas" (p. 106). Information gained from these two data collection procedures informed shadowing and the semi-structured interviews (see Table 2.4).

2.4.2.4.2 ***Documentation review***. Documentary information is an important source of evidence in case studies and has the advantages of being unobtrusive, covering long time spans, and being accessible for repeated review (Yin, 2014). The documentation that was examined in this study included: (a) reports entered into the health region incident reporting system; (b) communication books for NAs; (c) physician communication books; (d) nursing communication books; (e) resident charts; and (f) staff meeting minutes. The incident reporting system is used by staff in all 30 care homes as the mechanism to report assaults, injuries (staff and resident), equipment failures, pressure ulcers, and other critical incidents. The NA communication log is used by all staff as a way to alert care staff of general care plan changes for residents and other staffing or safety issues. The nursing communication book is a means for nursing staff to communicate issues related to medication changes, staffing or safety issues, and care plan changes. This information is only viewed by the nursing staff and the CNL. The physician communication book is used by both the physician and the nurses as an informal way to communicate medication and safety issues. The resident charts that were reviewed by the researcher were identified by the CNL and the GPA Coach in Home 6 and the full-time day RN in Home 7 at the beginning of this study. The CNL and GPA Coach in Home 6 and the full-time day RN in Home 7 described each resident selected as displaying "significant responsive behaviours." A total of six resident charts (n=6) were selected in each home. The documentation review included reviewing three months of documentation prior to the installation (Fixsen et al., 2005) of the GPA Program and then reviewing the same documents and resident charts approximately every three months for 14 months following program installation.

The researcher began the document review looking for indicators of staff using person-centered care and the GPA skills identified in the GPA training program in their daily practice.

This process was guided by the Person-Centered Care Skills (Appendix E) and the GPA Skills Appendix (Appendix F). For example, the researcher examined chart notes for incidents of staff being able to identify a trigger behind a behaviour for a resident with dementia. The researcher then identified in the resident chart if a plan was created to manage the behaviour and look for indicators of whether or not staff used the behavioural intervention over time. A key learning objective in the GPA program was for staff to understand that there is meaning behind a behaviour and that it is the responsibility of the staff to try to identify and manage the trigger behind the behaviour. In addition to the Person-Centered Care and GPA Observation Guides, the researcher also used the Facilitation and Leadership Observation Guides (Appendices G and H) to help identify the individuals who were using (or not using) facilitation and leadership skills to help implement and sustain the GPA program in the LTC homes.

2.4.2.4.2.1 *Document review data analysis.* During the data analysis phase, the writer used the constant comparative method identified by Charmaz (2006) in the retrospective study. Initial coding was followed by focused coding. In the document review, the researcher coded the incidents registered into the safety reporting system for each home. The reports were then compared against each other and compared over time. Finally, the reports were compared across the two homes to uncover the similarities and differences between factors that influenced sustainability (positively or negatively) of the GPA program. The NA, RN, and physician communication logs were coded individually for each home and then the codes were compared and contrasted against each other (e.g., codes from NA communication log in Home 6 against codes from the physician communication book in Home 6). The codes from the communication books were then compared across the homes (e.g., codes from NA communication book in Home 6 were compared against the codes from the NA communication book in Home 7). Finally, the codes from the communication books were then compared and contrasted across the communication books for both homes (e.g., codes from NA communication book in Home 6 versus codes from RN communication book in Home 7).

The resident charts were coded individually and then over time in each home (e.g., codes for resident 1 chart in Home 6 in December 2011 against the codes for resident 1 chart in Home 6 in March 2012) to look for indicators of facilitation, leadership, and the other i-PARIHS elements in relation to sustainability of the GPA program over time for each home. The researcher then compared the codes from each individual resident chart against the codes from

the other remaining five resident charts in each home (e.g., codes from resident 1 chart in Home 6 against the codes from resident 2 chart in Home 6) for each home. Finally, the codes from the resident charts in Home 6 were compared to those in Home 7 to identify similarities and differences that impacted sustainability of the GPA program over time (e.g., codes from resident 1 chart in Home 6 against the codes from resident 3 chart in Home 7). Staff meeting minutes were coded similarly to those of the incidents registered into the safety reporting system. They were coded individually, then over time for each home, and then across the two homes.

To complete the data analysis of the document review, the codes from the documents in each individual home were then compared and contrasted against each other (e.g., codes from the resident charts in Home 6 against the codes from the staff meeting minutes in Home 6, codes from the reports entered into the safety reporting system in Home 6 against the codes from the staff meeting minutes in Home 6). Finally, the codes from the documents in Home 6 were examined in relation to the codes from the documents in Home 7 (e.g., codes from the communication logs in Home 6 against the codes from the resident charts in Home 7) to gain an overall understanding of facilitation, leadership, and other factors related to the implementation and sustainability of a dementia specific training program in rural LTC homes.

2.4.2.4.3 *Observation*. Case studies typically occur in the natural setting of the case, creating the opportunity for direct observations of behaviours and environmental conditions (Yin, 2014). A total of 24 hours was spent in each of the homes observing staff from all departments across the two homes. As a non-participant observer, the researcher was observing staff for the use of the facilitation strategies as identified by Dogherty, Harrison, and Graham (2010) who created a list of attributes, skills, and interventions (Appendix G) by examining literature specific to implementation of evidence-based practice in the field of nursing. The researcher also observed for individual factors (e.g., facilitator approach and traits) and contextual factors (leadership, culture, workload) as identified by Janes et al. (2009). Activities that were observed included: shift exchanges, meal times, public staff/resident interactions, and recreational activities. The researcher completed all observations between 8:00 am and 5:30 pm during the week. It was not possible for the researcher to observe staff on nights, evenings, and weekends. Observations occurred only within the "public" areas of the care home and not within the resident's room or in other private areas (bathroom or tub areas).

The researcher observed for indicators of sustainability of the GPA program by looking for the specific tasks and interventions (e.g., communication skills, verbal and environmental de-escalation techniques) taught to staff in the 7.5 hour GPA training course (Appendices E and F). Appendix H guided observation for the leadership skills as described in the sustainability section of the literature review. All observations were written in a field journal and expanded into a word document after the observation. While in the field, the author used jottings that were used to turn the observations into field notes (Emerson, Fretz, & Shaw, 1995). The jottings consisted of key words, impressions, and conversations. The time, date, place, setting, and description of the physical environment were also recorded within the field notes. All field notes were completed immediately and reviewed bi-weekly with the researcher's doctoral supervisor.

Direct observations also helped to identify staff members to be shadowed. Shadowing in qualitative research occurs when a researcher follows a participant in their own environment for a set period of time to learn about their individual experiences (McDonald, 2005). Direct observations and the document review identified a continuum of individuals whose behaviours ranged from consistently being in alignment with the GPA skills and program philosophy to those whose behaviours did not. Shadowing was conducted with individuals on the extreme ends of the continuum and then with those whose behaviours varied to explore why the GPA skills were used in some scenarios and not in others. NAs, the CNL, and RT were shadowed in this study. The shadowing was guided by The Person-Centered Care, GPA Skills, Facilitation and Leadership Observation Guides (Appendices E, F, G, and H).

During the direct observations, because the researcher was not able to observe staff in resident rooms or private areas, she had brief discussions with the staff in situations when she heard a responsive behaviour coming from these areas (i.e., resident yelling during care) or when the NAs behaviour indicated a responsive event had occurred (i.e., NAs pointing to areas on their body to other NAs indicating where they had gotten hit during an interaction with a resident). The discussions centred on whether or not the staff de-escalated the responsive behaviour and what GPA skills (if any) they used to de-escalate the situation. The researcher also asked if they felt supported by their co-workers and the formal leaders in the home to use the skills taught in the GPA program. NAs (from both homes) (n=3), the DOC (Home 7), and RT (Home 7) participated in the brief discussions.

2.4.2.4.3.1 *Observation data analysis.* All of the observations were coded using the constant comparative method outlined in the retrospective study (Charmaz, 2006). The researcher initially coded all of the observations, then they were then compared over time for each home and then across the two homes. The same process was completed for the discussions with staff as described above.

2.4.2.4.4 *Semi-structured interviews.* Interviews are an essential source of case study information (Yin, 2014). Eight semi-structured interviews were completed with seven staff members from in Home 6: manager (*n*=2 interviews), NA (*n*=1 telephone interview), GPA Coach (*n*=1 interview), CNL (*n*=1 interview), ward clerk (*n*=1 interview), dietary staff/administrative support (*n*=1 interview), and RT (*n*=1 interview). These interviews were conducted in the LTC home in a private board room. A total of seven semi-structured interviews (*n*=7) with seven participants were completed with staff from Home 7: NAs (*n*=2), RN (*n*=1), GPA Coaches (*n*=2), administrative support (*n*=1), and RT (*n*=1). All interviews with the exception of one GPA Coach (telephone interview) were completed in a private room within the LTC home. The interview/focus guides that were used for the retrospective study were also used for the semi-structured interviews in this study (see Appendix D) and were subject to modification over time to reflect evolving themes. Each staff member was approached by the researcher and asked if they would be interested in participating in a 30 to 60 minute interview. Data from observations and the documentation review were used to guide initial selection of staff to interview. These sources of data identified for the researcher individuals who (a) used facilitation strategies to implement the GPA program within their home, and (b) demonstrated use of the GPA skills and interventions within their daily practice. Subsequent decisions were guided by theoretical sampling, where data collection was driven by the emerging analysis. Interviews were conducted with staff until all theoretical categories were full and robust or saturated (Charmaz, 2006). Interviews began in April 2012. All interviews were audio taped and transcribed by the researcher. Appendix D guided the interview process.

2.4.2.4.4.1 *Semi-structured interview data analysis.* Data analysis for the semi-structured interviews for Home 6 and 7 was completed using the constant comparative method (Charmaz, 2006) as outlined in the retrospective study. All of the semi-structured interviews were coded individually looking for factors influencing sustainability of the GPA program (e.g., leadership, facilitation and other i-PARIHS elements). Once the interviews were coded, the writer compared

and contrasted the codes from each participant group from Homes 6 and 7 against each other (e.g., codes from Home 6 GPA interviews against the codes from Home 6 dietary staff/receptionist interview). The next step in the data analysis was to compare the codes from each participant group from Home 6 against the codes from the same participant group (if possible) from Home 7. For example, the codes from Home 6 NA semi-structured interviews were compared against the codes from Home 7 NA semi-structured interviews. Lastly, the codes from the semi-structured interviews were compared and contrasted across the participant groups from Homes 6 and 7 (e.g., the codes from the GPA Coaches semi-structured interviews in Home 6 were compared against the codes from the NA semi-structured interviews from Home 7).

Table 2.4

Prospective Study Data Collection Procedures and Participant Roles

Home	Participants in Semi-Structured Interviews	Data Collection Procedures	Number of Interviews/Hours of Observation /Data Review Sources	Total Number of Participants, Semi-Structured Interviews
Home 6	Manager (*n*=1), CNL (*n*=1), NAs (*n*=1), RT (*n*=1), Dietary/Administrative support (*n*=1), GPA Coach (*n*=1), and Ward Clerk (*n*=1)	[a] Direct Observation	24 Hours	Total Participants N=7
		[a] Shadowing	15 Hours	
		Semi-structured Interviews	Formal Leader Interviewed: Manager (*n*=2) Direct Care Staff Interviewed: NAs (*n*=1), GPA Coaches (*n*=1), CNL (*n*=1), RT (*n*=1) Ancillary Staff Interviewed: Ward Clerk (*n*=1), Dietary/administrative support (*n*=1)	Total Semi-structured Interviews N=8
		Document Reviews	Incident Reports, Nursing Communication Book, NA Communication Book, Physician Communication Book, 6 Resident Charts, Staff Meeting Minutes	

Table 2.4 Continued

Home	Participants in Semi-Structured Interviews	Data Collection Procedures	Number of Interviews/Hours of Observation /Data Review Sources	Total Number of Participants, Semi-Structured Interviews
Home 7	RN (*n*=1), NAs (*n*=2), RT (*n*=1), GPA Coaches (*n*=2), Administrative support (*n*=1)	[a] Direct Observation	24 Hours	Total Participants N=7
		[a] Shadowing	15 Hours	
		Semi-structured Interviews	Formal Leaders Interviewed: N/A Direct Care Staff Interviewed: RN (*n*=1), NAs (*n*=2), GPA Coaches (*n*=2), RT (*n*=1) Ancillary Staff Interviewed: Administrative Support (*n*=1)	Total Semi-structured interviews N=7
		Document Reviews	Incident Reports, Nursing Communication Book, NA Communication Book, Physician Communication Book, 6 Resident Charts, Staff Meeting Minutes	
Total				14 Participants 15 Semi-Structured Interviews

Note. Clinical Nurse Leader = CNL. Registered Nurse = RN. Nursing Aides = NAs. Recreation Therapist = RT. Direct Care Staff included CNL, Nurses, NAs, RTs, and GPA Coaches. Formal Leaders included Administrators, Managers, and Director of Care. Ancillary staff included all other staff members in the LTC home.

[a]Role of participants who were shadowed and participated in the brief discussions are outlined in the text.

2.4.3 Data Analysis Framework for the Retrospective and Prospective Studies

Developing an analytic strategy is key when planning a case study design (Fitzgerald & Dopson, 2009; Yin, 2014). Without an analytic strategy, (a) a researcher may collect data that are not relevant to the research questions, (b) the data may not be collected in a scientific, robust way, and (c) the researcher may not consider all rival explanations or alternative interpretations of the data during data analysis (Yin, 2014). According to Yin (2014), the analytic strategy should follow a cycle that involves the research questions, the data collected, the interpretation of the data, and the ability of the researcher to make some assertions about the data. The analytic strategy then steers the researcher through the data analysis phase.

2.4.3.1 Within-case analysis. The data from the five retrospective and two prospective study homes were each analyzed individually as a case (Yin, 2014). An inductive, grounded approach was used within each case, using the constant comparative method (Charmaz, 2006) to analyze data from the interviews and focus groups in the retrospective study, and the document review, shadowing, observations, and semi-structured in the prospective study. Yin refers to the inductive approach as the "surfacing of a new concept or theme" (2014, p. 135).

2.4.3.2 Cross-case analysis. For the cross-case analysis, two of the four general strategies identified by Yin (2014) were used: relying on theoretical propositions and examining rival explanations. A theoretical proposition "helps to organize the entire analysis, pointing to relevant contextual conditions to be described as well as explanations to be examined" (Yin, 2014, p. 136). The theoretical proposition that guided the retrospective and the prospective studies was that *facilitation leads to the sustainability of evidence-based practice*. A rival explanation is an alternative explanation for the study findings (Yin, 2009). The rival explanation that was focused on within the cross-case analysis was that *leadership rather than facilitation leads to the sustainability of evidence-based practice*.

Yin (2014) also described *specific* analytic techniques to be used along with the general strategies. The retrospective and prospective studies drew on the pattern-matching, explanation building, and cross-case synthesis techniques for the cross-case analysis (Yin, 2014). *Pattern matching* involves an attempt to link two patterns, where one is theoretical and the other is observed. The more that the patterns match, the more support the findings provide for the propositions guiding the research (Trochim, 1989). In this study the analysis between the cases looked for factors associated with sustainability. Within the prospective study, the two cases

were selected with the expectation of contrasting results for reasons that we were able to anticipate (a theoretical replication; Yin, 2014). The proposition within the prospective study was that *more and better facilitation would lead to enhanced sustainability in the home that had a full-time manager, a CNL, and professional staff as GPA Coaches*. *Explanation building* is an iterative process of comparing findings of the first case to the initial theoretical proposition, revising the proposition, and comparing the evidence from the next case, to gradually build an explanation about how and why events occur. During this process the researcher must be open to and examine other potential rival explanations (Yin, 2014). The *cross-case synthesis* technique is a complementary process that involves treating each case as a separate study, then examining overall patterns of findings across all cases (seven homes in this study) to probe for similarities and differences (Yin, 2014).

2.4.3.3 Drawing overall conclusions from the two studies. The final step of the analysis was to derive conclusions or inferences from the combined findings of the retrospective and prospective studies. An interpretive pattern-matching approach was used to compare the pattern of findings between the two studies, keeping in mind the core research question of relationships between facilitation and sustainability. Potential rival explanations, including all other i-PARIHS elements (including leadership) were also examined.

2.4.4 Trustworthiness

In order to enhance trustworthiness within this study, the researcher used several methods that contributed to credibility, transferability, dependability, and confirmability of study findings (Lincoln & Guba, 1985).

2.4.4.1 Credibility. Strategies to support credibility are aimed at promoting confidence that the researcher has accurately captured the phenomenon being studied (Lincoln & Guba, 1985). Throughout the data collection and analysis phase, the researcher improved credibility of research findings using several different methods. First, data collection in the prospective study occurred over a 15-month period (prolonged engagement; Lincoln & Guba, 1985) in which the researcher spent approximately two days every three weeks in each home (data collection alternated between the two LTC homes). Over this time period, the researcher was able to become familiar with the setting and culture of the two LTC homes, as well as learned to overcome preconceived notions that the researcher had about how staff provide care and interact with residents. For example, the researcher believed that the staff would always be in a rush

when interacting with residents at all times and that ancillary staff would have few meaningful interactions with residents who lived in the homes. This was not the case with all of the staff, all of the time. These pre-conceived notions were overcome as the researcher observed staff over time and witnessed that many staff treated the residents as if they were a member of their own family. The pre-conceived notions were written in the field notes, reflexive journal, and discussed with the researcher's supervisor as they arose. Prolonged engagement allowed the researcher to build trust with the participants so that they felt comfortable around the researcher, particularly during the interviews and observation periods.

Second, in addition to prolonged engagement (Lincoln & Guba, 1985), the researcher also was able to spend over 24 hours in each home observing and 15 hours shadowing the staff to learn about the culture and routines of the staff in the prospective study. Persistent observation (Lincoln & Guba, 1985) helped the researcher ascertain which factors were the most important and applicable in the research setting and which ones were not. For example, in the prospective study homes, the researcher discovered that the roles, characteristics, and attributes of the formal leader played a significant role in whether or not staff use GPA skills in their day to day clinical practice. Prolonged engagement and persistent observation (Lincoln & Guba, 1985) enabled the researcher to witness the impact that the formal leader had on staff. The relationship between sustainability and leadership may not have emerged as strongly if data collection had included only interviews and document reviews.

Third, according to Lincoln and Guba (1985) triangulation of data is another way in which a researcher is able to enhance credibility of study findings. Data triangulation support the development of "converging lines of inquiry" and therefore more convincing and accurate conclusions (Yin, 2014, p. 120). The researcher used two types of triangulation: source and method (Lincoln & Guba, 1985). For both studies, the researcher interviewed, observed, and shadowed various participants from different departments (source triangulation). For example, in the retrospective study, the DOCs/managers/administrators, GPA Coaches, RNs, and NAs were interviewed. In the prospective study, the researcher observed maintenance and the kitchen staff interacting with residents, and interviewed NAs, GPA Coaches, formal leadership, CNL, etc. For method triangulation (Lincoln & Guba, 1985), the researcher analyzed the data from all of the interviews, focus groups, observations, shadowing, and document review on their own for each home. Then, the results of each data collection method were compared against each other within

and across each home for both studies (e.g., interviews against observations, observations against focus groups, interviews against focus groups). Fourth, peer debriefing was used to strengthen credibility by allowing a fellow researcher to examine the findings for bias, honesty, and the testing of emerging relationships in the data (Lincoln & Guba, 1985). To accomplish this, the researcher's doctoral supervisor reviewed the field journal and all of the data collected on a bi-weekly basis.

2.4.4.2 Transferability. After a researcher has completed their final report, it is important for readers to make a decision on whether or not the conclusions can be transferred to other contexts, settings, situations, times, or people. Transferability (Lincoln & Guba, 1985) is supported when the researcher provides enough detail or "proper thick description" (Lincoln & Guba, 1985, p. 316) for the reader to make the decision on whether or not the conclusions can be transferred. Thick description occurs when the researcher collects data about the context that is rich and detailed (Stake, 2006). In the current study the researcher described all of the observations and interactions that occurred during shadowing in detail in the field journal. In addition, the researcher elicited comprehensive answers from participants during the formal and informal interviews. Throughout the document reviews, the writer recorded poignant and emotional chart entries by staff who were working with residents with extreme responsive behaviours.

2.4.4.3 Dependability. To achieve dependability, it is important for the researcher to have a fellow researcher conduct an inquiry audit (Lincoln & Guba, 1985). An auditor is brought in by the researcher to review the process that was undertaken during the data collection and analysis phase as well as to examine the final product. A researcher from the doctoral committee reviewed the data gained through the semi-structured, shadowing, document review, focus groups and observations in both studies after data collection was completed. The author also met with the committee member, in conjunction with her doctoral supervisor, once per month to review how the data were analyzed and to assess the results of the retrospective and prospective studies.

2.4.4.4 Confirmability. The author also established an audit trail so that future researchers could review the steps taken from the beginning of the project to the final report (Lincoln & Guba, 1985). The writer kept all of the raw data (e.g., field journal, voice recording, transcriptions of interviews and focus groups, documentation review information) in encoded

files on a password-protected computer. All of the coded documents and data reduction charts as well as all jottings and field notes were kept in a locked filing cabinet. A field journal was used and memos were completed to "map activities in support of maintaining the audit trail" (Birks & Mills, 2015, p. 50). The field journal and memos were reviewed by the researcher's doctoral supervisor every two weeks throughout the data collection phase of both studies. Finally, a reflexive journal (Lincoln & Guba, 1985) was also kept throughout this research project so the researcher could record her thoughts and feelings about what she had learned about herself during the research process, and why certain methodological decisions were made. Entries were completed whenever the researcher was in the field or when changes to the methods occurred.

2.4.5 Consent and Data Storage

Participation in this research project was voluntary. Operational approval was sought at the individual and organizational levels within the care homes as well as from the health region research office, and the University of Saskatchewan Behavioral Research Ethics Board. Ethics approval was received for this study on October 11, 2011 (Beh # 11-244). Managers/DOCs/ administrators were asked to have their care home participate in this research study. They were asked if the researcher could shadow staff and grant the researcher access to written documentation. Staff/residents/families were able to opt out of the observation that occurred in the "public" areas of the LTC homes by asking the researcher not to observe them or their family member. This message was conveyed to staff and families at the beginning of the data collection by the managers/administrators/DOCs through verbal and written communication. Focus groups and semi-structured interviews occurred after the staff member had given written consent (or verbal consent if they had difficulty with English as a second language; See Appendix C). All stakeholders who agreed to participate in this study remained anonymous. Aside from the first author's supervisor and the researcher who did the audit, only the researcher had access to the interview and focus group data. The initial audio recordings of the semi-structured interviews and focus groups, as well as all other data sources, were saved encoded on the researcher's computer. Data were stored in a locked cabinet under the supervision of the researcher's doctoral supervisor at the University of Saskatchewan for five years after completion of the study.

CHAPTER 3.0: THE IMPACT OF LEADERSHIP AND ORGANIZATIONAL CULTURE ON SUSTAINABILITY OF A DEMENTIA-SPECIFIC TRAINING PROGRAM IN RURAL LONG-TERM CARE HOMES (PAPER 1)

3.1 Background

According to the World Health Organization (2017), there are approximately 47 million people globally who have been diagnosed with some form of dementia. By the year 2030, 75 million people will be living with dementia and these numbers are expected to triple by 2050. In Canada, there are almost a half a million people who have been diagnosed with dementia and another 25,000 people will continue to be diagnosed yearly (Alzheimer Society of Canada, 2018a). Given the increase in the number of people living with dementia, it is important that health care systems worldwide are prepared to manage the surge of people requiring services. This is especially important in rural and remote areas across Canada where rural seniors have limited access to emergency medical services, long-term care beds (Sapru et al., 2014), and fewer doctors and nurses (Meit et al., 2014).

Clinicians who practice in rural and remote areas encounter barriers that their urban counterparts do not experience. For example, they struggle with isolation (Hunt & Hunt, 2016), experience unfavourable working conditions (Weinhold & Gurtner, 2014), and have a higher patient volume (Hunt & Hunt, 2016). Additionally, health care practitioners, particularly nurses, are expected to have a broad knowledge base and be proficient in many areas as they have to deal with a wide range of health care issues (Chipp et al., 2011; deValpine, 2014; Stewart et al., 2005). Staff in long-term care (LTC) homes in both urban and rural areas often have not received appropriate training to prepare them for working in care homes (Eaton, 2003; Hudson, 2003). Although staff members in LTC homes care for residents with dementia, many of these individuals feel as if they do not have understanding of what dementia is (Jones et al., 2013) and they believe that they do not have the appropriate set of skills to work with individuals who display responsive behaviours (Gates et al., 2005). It is, therefore, important to provide dementia-specific training to staff in rural areas and rural LTC homes (Daniels et al., 2007; Morgan et al., 2011; Moyle et al., 2010).

A sustainable, in-house training program is one way to provide education for staff in rural LTC homes as they may have difficulty accessing current research (Weinhold & Gurtner, 2014), and continuing education opportunities (Hunt & Hunt, 2016), and often lack computer, internet, or research skills (Winters et al., 2007). Other barriers include time constraints at work to look up current research (Winters et al., 2007) and long distances to travel away from home to attend continuing education opportunities (Fitzgerald & Townsend, 2012; Winters et al., 2007). Providing training for staff in their place of employment builds their skill set (Grand et al., 2011) and builds the capacity within the organization so staff members do not burn out (Morgan et al., 2011) or have to rely on external dementia specialists to help manage responsive behaviours displayed by residents with dementia (Morgan et al., 2011). This paper examined the characteristics of formal leaders in rural LTC homes and how they influenced the sustainability of a dementia-specific training program for staff.

3.1.1 Person-Centered Care

Within society, there has been a push to change how residents with dementia are treated with the emphasis moving away from the medical model of care to one that is person-centered. The medical model or institutional model (the term that will be used in this paper) of care focuses on the negative aspects of being diagnosed with dementia. People with dementia are viewed as living a life with no value or meaning and are believed to be "suffering" through the dementia journey (Clarke et al., 2016). Within this paradigm, labelling, stigmatizing, and isolation are common (Brooker & Latham, 2016). Staff may use language to refer to individuals with dementia by their diagnosis, room number, responsive behaviour, or symptoms (Duffy, 2016; Fox, 2007). Care is organized around tasks, schedules, and needs of staff and the organization (Fazio, Pace, Flinner, & Kallmyer, 2018). Individuals with dementia in these homes are viewed as being frail, helpless, incapable of living a life of meaning, and no longer able to make choices on their own (Duffy, 2016; Fox, 2007; Norton & Shields, 2006). Because of this worldview, staff members fail to take into account the life history, likes, and dislikes of residents with dementia (Harnett & Jönson, 2017), thus leading to interactions that are not meaningful.

The work of Tom Kitwood (1997) centres on developing personhood and changing the care of people living with dementia from an institutional model to a person-centered model. Personhood signifies that individuals with dementia are able to connect with and maintain deep relationships with the world around them as their dementia progresses. Person-centered care

focuses on the individual with dementia and acknowledges their likes, dislikes, history, and experiences, instead of completing care around the schedule, routine, values, and beliefs of the staff. Many LTC homes across the globe are changing their culture from one that is institutional in nature to providing care that is based on staff knowing and valuing the person for whom they are caring.

Within a person-centered culture of care, the language that is used reflects the personhood of the individual with dementia. Rather than using labels such as "feeder," "wanderer," hoarder," describing a resident by a task (e.g. put down, changed, or walked), or referring to a behaviour as "challenging," "manipulative," or "aggressive," in a person-centered care environment staff refer to an individual by their name of choice, and view behaviours and emotions as expressions of an unmet need. According to Talerico and Evan (2000), behaviours are a way for a resident with dementia to signify to their caregiver that there is something wrong in their environment. When the behaviours are reframed as "responsive" it directs staff to look for a trigger or unmet need and provide care in a way that is respectful and person-centered. The term "responsive behaviours" will be used throughout this study as it is in alignment with person-centered care language and indicates that behaviours are an expression of a unmet need or as a result of a problem (e.g., physically, environmentally, socially, spiritually) and the person with dementia is not able to communicate this to their caregivers (Talerico & Evan, 2000). Additionally, the terms physically responsive behaviours will be used in place of "violence," "aggression," "agitation," "assaults," "physical abuse" and verbally responsive behaviours will be used in place of "verbal abuse," "verbal aggression," or "emotional abuse."

As a part of the dementia journey, an individual may experience changes in their physical health, personality, reasoning, judgment, memory, and behaviours (Alzheimer Society of Canada, 2017b). Within the literature, agitation (Cerejeira et al., 2012; Selbæk et al., 2013; Zwijsen et al., 2014), resistance to care, and inappropriate social and sexual acts (Davison et al., 2017) are a few of the behaviours that have been commonly displayed by residents with dementia. Kolanowski and Garr (1999) found that 40% of residents with dementia display responsive behaviours, while Selbæk et al. (2013), reported that up to 80% of residents with dementia living in a LTC home exhibit some type of responsive behaviour. Likely due to the population being studied, the measures that are being used, and the chronic underreporting of

responsive behaviours, there is variability related to the proportion of residents living in LTC who display responsive behaviours (Scott et al., 2011a).

3.1.2 Need for Dementia-Specific Training Programs

Staff who work in dementia care areas are exposed more frequently to both physical and verbal responsive behaviours as compared to who those who work in hospitals (Boström et al., 2012). Additionally, two-thirds of Licensed Practical Nurses and nursing aides (NAs) who worked in four dementia care areas experienced a physical or verbal responsive behaviour over a one month time period (Boström et al., 2012). Experiencing responsive behaviours can cause lasting effects on staff members, particularly on their physical, emotional, and mental health (Edward et al., 2014; Isaksson et al., 2011; Scott et al., 2011a, 2011b). For example, staff may question why they work in LTC homes (Needham et al., 2005), may experience burnout (Estabrooks et al., 2015), and may spend less time with the residents they care for (Scott et al., 2011a, 2011b). Thus it is important to support staff who work in LTC homes with residents with responsive behaviours. There is evidence that a dementia-specific training program can provide staff with the skills to safely minimize and de-escalate responsive behaviours (Alzheimer Society of Canada, 2010; Aylward et al., 2003; Morgan et al., 2007; Morgan et al., 2005; Scott et al., 2011a, 2011b; Snellgrove et al., 2015; Spector et al., 2013).

Within health care, there is a gap between the creation of new ideas, programs, and innovations, and the actual use of this knowledge in practice (Bradley et al., 2004; Davis et al., 2003). This gap is likely related to the large amounts of programs and initiatives with which health care providers are inundated, or the fact that the new idea or innovation did not work as well in the real work as it did in clinical trials (Greenhalgh et al., 2014). Historically, once new research findings were “pushed out” (Nutley et al., 2003), they were expected to automatically be used within practice (Ilkiw-Lavalle et al., 2002; Nutley et al., 2003). In health care settings, passive dissemination of training programs are not the most effective means for changing practice (Caspar et al., 2016; Davis et al., 2003), yet this seems to be the most common method of educating staff (Caspar et al., 2016). According to Handley, Bunn, and Goodman (2017), training programs as the only approach to engage staff in practice change is not enough to create a new culture for people with dementia.

3.1.3 Conceptual Framework

To effectively change the practice of staff in LTC homes, alternative approaches to passive dissemination of information must be used. Implementation science has evolved as a way to overcome the barriers (e.g., patient and clinician motivation and adherence to new ideas) that inhibit programs from being sustained in health care settings. Implementation science refers to the "scientific study of methods to promote the systematic uptake of research findings and other innovations into routine practice, and hence, to improve the quality and effectiveness of health services" (Eccles & Mittman, 2006, p. 1). In order to sustain innovations and programs, implementation must be a planned and coordinated process that recognizes that the clinician, the patient, the context, and the entire health care system play a significant role in sustainability. The Integrated Promoting Action on Research Implementation in Health Services (i-PARIHS) framework was used to guide the current research, to gain an understanding of the factors that are related to the sustainability of educational programs in LTC homes.

In the i-PARIHS framework (Harvey & Kitson, 2015b), *successful implementation* of evidence-based practice is the result of the "facilitation of an innovation with the recipients in their (inner and outer) context" (p. 40). Successful implementation occurs when the stated goals of the project have been achieved, the clinicians and teams feel as if they "own" the program, the skills are being used in day to day practice, and there is little variability between health care settings (Harvey & Kitson, 2015b). The term *sustainability* will be used within this research study to reflect the idea of successful implementation, as the concept of sustainability is implied in other terms in the i-PARIHS literature (e.g., practice change, uptake of knowledge, success).

Facilitation is defined in i-PARIHS as the method for changing practice (Harvey & Kitson, 2015a). It is the "how" component of the implementation process. It involves a formal facilitator with the proper skills, who has an understanding of the innovation and the context in which the program is being implemented. *Innovation* is the idea or the "what" that is being implemented. *Recipients* are the individuals who play a significant role in the implementation process, whereas *context* refers to "where" the innovation is being placed. Context can be broken down into inner and outer contexts of an organization. The inner context is the exact location (e.g., LTC neighbourhood, hospital ward) where the innovation is being implemented and the organization is the larger setting in which the location of implementation is situated (e.g., LTC

home, hospital). The outer context is the larger health care setting including all of its policies, procedures, and laws.

Within the inner context, Harvey and Kitson (2016) identified characteristics that need to be considered when working towards implementation of an innovation and sustained practice change. At the local level, these included: leadership support (both formal and informal), culture, past history of working with new innovations and practice change, evaluation and feedback mechanisms, processes for embedding change, and type of learning environment (Harvey & Kitson, 2016). At the organizational level it is important to reflect on upper management and senior leadership support, culture, history of change and implementing new ideas, and what types of learning networks are found within the organization. It is the inner contextual level (both at the location of implementation and the overall organization) that the current research is focused on (Harvey & Kitson, 2016). Specifically, this study examined the relationship between leadership and the sustainability of a dementia-specific training program in rural LTC homes which is the rival hypothesis (to facilitation leading to the sustainability of evidence-based practice).

3.1.4 The Role of Leadership in Sustaining Innovations

There is a paucity of research on the characteristics of leaders that impact the sustainability of the innovation as well as agreement on the position of leadership within the organization (Stetler et al., 2014). Given that there are several leadership positions in LTC homes (e.g., manager, administrator, head nurse), it is imperative to gain an understanding of what characteristics are required of leaders to help sustain practice change and improve the quality of life for residents. What is evident about leadership is that it is a vital component in the sustainability of new evidence-based practices (Fleiszer et al., 2015a, 2015b; Higuchi et al., 2017; Wallin et al., 2003). Staff members need the support of their leaders to enable them to use new research in their current practice (Boström et al., 2009).

The research on leadership in nursing literature has pointed to the fact that leadership is not a sole position or a formal position, but is a social process conducted by many individuals across the organization, who use a multitude of skills to promote and sustain change (Øye et al., 2016). In the i-PARIHS framework, leadership is a contextual factor linked to successful implementation (Harvey & Kitson, 2015a). Thus, it is important to examine leadership in the current study, which focuses on the sustainability of a dementia-specific training program in

LTC. This research is a part of a larger study that explored how facilitation and leadership were related to the short-term sustainability of The Gentle Persuasive Approaches (GPA) program in rural LTC homes. This paper reports the findings related to the relationship between leadership and sustainability of the program over a 15-month period following program installation (Fixsen et al., 2005). According to Fixsen et al. (2005), there are six stages in the implementation process: exploration and adoption, program installation phase, initial implementation, full operation, innovation, and sustainability. The GPA program is considered fully installed when all resources required to support the program (e.g., space, computers, selection and training of the GPA coaches) are in place and all staff in the LTC homes have received the 7.5 hour training course. The research question that guided this study was "*What is the role of leadership in sustainability of the GPA program in rural LTC homes?*

3.2 Methods

3.2.1 The Intervention

The GPA program is a dementia-specific training program initially created for staff in LTC homes to help them identify and manage responsive behaviours displayed by residents with dementia in a safe and respectable way (Schindel Martin & Dupuis, 2005). All of the staff (i.e., nursing aides (NAs), nurses, housekeeping, dietary, maintenance, and administration) within the LTC home participate in the 7.5 hour training program that is delivered within the home. At the time of data collection for this study, the GPA Course was taught using the "train the trainer" teaching method. To become certified as GPA Coaches, two staff members from each LTC home participated in a two-day training course taught by GPA Master Coaches. The GPA Coaches then returned to their own LTC home and taught the 7.5 hour training program until all of the staff had attended the training. The GPA course is based on the most current dementia research and adult learning principles. The course is taught to a maximum of 12 participants using video clips, role plays, self-reflection exercises, and group discussions. The course is divided into four modules that review person-centered dementia care, brain and behaviour in residents with dementia, environmental and communication skills, and the gentle persuasive techniques that staff are able to use to help manage physically responsive behaviours.

3.2.2 Retrospective and Prospective Study Methods

In order to study the relationship between short-term sustainability and leadership, seven LTC homes were selected for an explanatory, holistic, multi-case study research design. A

retrospective study in which the GPA program had been fully installed (Fixsen et al., 2005) in five rural LTC homes was completed in conjunction with a *prospective study* that began with the start of the program installation phase in two rural homes and followed the implementation process over 15 months. The studies were conducted simultaneously in the same health region and provided the opportunity to observe how facilitation and leadership influenced sustainability from two vantage points: looking forward and backward in time. Case study methodology is ideal for studying complex phenomenon using multiple data collection strategies (Yin, 2014). The gradual implementation of a dementia- specific training program in rural LTC homes in a health region on the Canadian Prairies provided a lens into the complex processes associated with sustainability.

3.2.3 Retrospective Study Design

This study used a multi-site case study research design in which cases were selected based on the design logic of "matching" cases (Fitzgerald & Dopson, 2009) Two matching criteria were used for the selection of five homes: rural locality and complete installation of the GPA program. Data were collected at one point in time (i.e., at the time of interview or focus group attendance) approximately 12 to 15 months after the GPA program had been installed.

3.2.3.1 Setting and site selection. The study setting was a large health region on the Canadian Prairies. There is one large urban centre defined by Statistics Canada, (2017b) as having a population of 100,000 or more, and 30 LTC homes in the health region. Sixteen of these homes are located outside of the urban setting and were considered rural because they did not receive the same support or resources as the urban LTC homes. For example, the rural LTC homes did not have access to geriatric psychiatrists or community mental health nurses. In this health region, there are LTC homes that are owned and operated by the health region (one home in this study) and homes that are independently owned and operated by a board of directors (four homes in this study). Of the 16 rural LTC homes, seven had installed the GPA program at the time of data collection, five of which were selected for the retrospective study (Homes 1-5). Two homes that were the pilot sites for the GPA program in the health region were excluded. The five LTC homes within this study were located from 30 km to 200 km away from the large urban population centre. Three of the homes met the definition of small population centre (population between 1,000 and 29,999) and two were classified as rural (under 1,000 population) as defined by Statistics Canada (2017b). The three LTC homes located in the small population centre were

included in the retrospective study because they had access to fewer services (e.g., no geriatric psychiatry coverage) when compared to the LTC homes in the large population centre and are considered rural by the health region. With fewer services, staff will have had limited access to mentoring, coaching, and support in managing responsive behaviours displayed by people with dementia.

Four of the LTC homes in this study were independently owned and operated (but report to the board and to the health region). The management structure in these four homes included full-time administrators (except in Home 5) and three homes employed part-time DOCs (Home 4 had a full-time DOC). The number of beds in the independently owned and operated homes ranged from 17 to 36. The position of the GPA Coaches in Homes 2, 3, and 4 were an RN and a NA, while in Home 5 the GPA Coaches were NAs. Home 1 was owned and operated by the health region and had 39 beds. This home employed a full-time manager only and the GPA Coaches were NAs. See Table 2.1 for the characteristics of the five LTC homes selected for this study.

3.2.3.2 Participants. In the homes that were owned and operated by the health region, there were managers and Clinical Nurse Leaders (CNL). Managers are in a formal leadership role and are responsible for (but not limited to) the overall building maintenance, budget, and hiring and supervising staff. The CNL is a clinical position that includes providing clinical support to the nurses and NAs, working with physicians in providing medical care to residents, educating staff on topics relevant to LTC, and liaising with families about their questions or concerns. The CNL reports directly to the manager of the LTC home but is expected to provide supervision to staff when the manager is away. Within the independently owned homes, directors of care (DOC), and administrators are in formal leadership roles. The DOC is responsible for (but not limited to) hiring and supervising the clinical staff, providing support to families, and ordering equipment. The duties of the administrator are similar to those of the manager in the health region owned and operated homes, with the exception of hiring clinical staff.

Registered Nurses (RNs) are those individuals within the LTC homes who have a diploma or bachelor's degree in nursing. Registered Psychiatric Nurses (RPNs) have a degree or diploma in psychiatric nursing. Licensed Practical Nurses (LPNs) have a two-year diploma in practical nursing. RN, LPN, and RPN roles in LTC include (but not limited to) administering medications, communicating with families and physicians, and clinical supervision of the NAs.

NAs are required to have a 32-week training course (total of 54 credit units) prior to finding employment in a health region. However, there is an option of completing the course within two years of employment. The curriculum covers topics from basic care to safety in the work place. Within this course, NAs take four credit units (out of 54) focused on dementia care and one credit unit for the Professional Assault Responsive Training program. The GPA Coaches are staff members from within the care homes who teach the training course to staff in all departments in the home. In the retrospective study, NAs, RNs, and a Recreation Therapist were trained as the GPA Coaches. Administrators (*n*=3), DOCs (*n*=2), managers (*n*=1), CNL (*n*=1), GPA Coaches (*n*=5), RNs (*n*=3), and NAs (*n*=16) participated in the semi-structured interviews and focus groups. See Table 2.2 for a detailed account of participants within this study.

3.2.3.3 Data collection. Data collection began February 1, 2012 and was completed January 31, 2013. See Table 2.2 for a detailed description of the data collection methods and participants by care home.

3.2.3.3.1 ***Semi-structured interviews.*** The aim of the interviews was to explore participants' perspectives of the relationship between leadership and sustainability of the GPA program. In both the retrospective and prospective studies, two groups of participants were interviewed: formal leaders (administrators, managers, DOC) and direct care staff (nurses, GPA Coaches, CNLs) (see Appendix D). The manager, an RN, a CNL (telephone interview), and a GPA Coach (*n*=4) participated in the semi-structured interviews in Home 1. In Home 2, the administrator, a GPA Coach, and an RN were interviewed (*n*=3). Two semi-structured interviews (*n*=2) were completed in Home 3, one with the DOC and one with the two GPA Coaches who were interviewed together. In Home 4, a total of five (*n*=5) semi-structured interviews were completed: one with the administrator and DOC (interviewed together), one RN, one GPA Coach, one RT (telephone interview), and one NA (see below). In Home 5, only the administrator was interviewed. The DOC (also the regular floor RN) participated in the focus group (see below). Two of the semi-structured interviews in this study were completed by telephone, with the remainder conducted in a private room at the LTC home. All interviews were audio recorded and transcribed verbatim by first author. See Table 2.2 for further details.

3.2.3.3.2 ***Focus groups.*** Focus groups were conducted to maximize the number of NAs who could participate. Four focus groups were held in five of the LTC homes (see Table 2.2 for description of focus group participants and Appendix D for the focus group interview guide.).

Home 4 did not have a focus group as it was cancelled twice due to conflicting issues and priorities in the LTC home. Only one NA participated when the third group was scheduled so an individual interview was conducted. The focus groups were held in a private room at the LTC home. They were audio recorded and transcribed verbatim by the first author. In Home 5, the DOC attended the focus group because she was the LPN on shift that day and was invited by the NAs to participate with them. The NAs expressed that they felt comfortable in discussing the role of leadership in relation to sustainability of the program.

3.2.3.4 Analysis. The constructivist approach to grounded theory as described by Charmaz (2006) informed this study. According to this approach, (a) the voices and experiences of the participants are integral in the collection and analysis of the data, (b) there are multiple, co-constructed realities, (c) researchers play a part in the data collection and analysis process, and (d) the data is co-constructed by the participants and the researcher (Charmaz, 2008). The constant comparative method was used to analyze the data (Charmaz, 2006). The researcher compares and contrasts the data, the established codes, and the larger categories that evolved from the data. This is an interactive process in which the researcher interacts with and revisits the data throughout data analysis. Incidents are compared within interviews and at different times, or incidents across-cases. The within and cross-case analyses were conducted in both the retrospective and prospective studies and will be discussed in the prospective study methods.

3.2.4 Prospective Study Design

The installation of the GPA program created an opportunity to study the relationship between leadership and sustainability of the GPA program in two rural LTC homes over a prolonged period of time. The prospective study was conducted using a longitudinal, multi-case case study design, where two rural LTC homes were selected based on the comparison of difference design logic (Fitzgerald & Dobson, 2009). According to Fitzgerald and Dopson (2009), researchers using this design logic select their cases based on predicted differences for anticipatable reasons. The data collection for this study began 6 weeks after the start of program installation (Fixsen et al., 2005) and continued for 15 months.

3.2.4.1 Site selection. Four LTC homes (in the same health region as the retrospective study) began to install the GPA program between September and October 2011. Two of these homes (Homes 6 and 7; see Table 2.3) were purposefully selected to maximize differences between the homes on factors that might influence the sustainability of the GPA program:

owner-operator model (independently owned and operated versus health region owned and operated), management and reporting structure (a manager and a CNL versus part time administrator and DOC and no CNL), and position of the GPA Coaches (LPN/CNL versus NAs). One of the LTC homes was located in a small population centre, while the other one was classified as rural based on the Statistics Canada definitions noted earlier (2017b). Home 6 (35 beds) was owned and operated by the health region and employed a full-time manager and a CNL. The GPA Coaches were the CNL and an LPN. Home 7 was independently owned and operated and employed a part-time administrator and a part-time DOC (no CNL). The GPA Coaches were NAs and there was no CNL in this home. The owner-operator model provided a contrast in how LTC homes can chose to prioritize their funding. The independently owned and operated LTC homes are able to choose what priorities or what positions want to fund, whereas health region owned and operated homes are given little flexibility with their funding. The leadership structure may provide insight into how the formal leadership position (e.g., whether they are full-time or part-time) may influence the sustainability of the GPA program. The difference between position of the GPA Coach within the LTC home (i.e., GPA Coach as CNL or NA) may also influence sustainability.

3.2.4.2 Participants. Staff members across all of the departments participated in this study. Managers (*n*=1), CNL (*n*=1), NAs (*n*=1), RT (*n*=1), dietary/administrative support (*n*=1), GPA Coach (*n*=1), and ward clerk (*n*=1) participated from Home 6. In Home 7, RNs (*n*=1), NAs (*n*=2), RT (*n*=1), GPA Coaches (*n*=2), and administrative support (*n*=1) participated in this study. See Table 2.4 for a detailed description of the participants, roles, and data collection methods by LTC home.

3.2.4.3 Data collection procedures. Data collection for the prospective study occurred over 15 months (December 1, 2011 - February 28, 2013). The researcher alternated between Home 6 and Home 7, spending two days per week collecting data. Three data collection methods were used to gain an understanding of the relationship between leadership and sustainability of the GPA program: document reviews, direct observation, and semi-structured interviews. See Table 2.4 for data collection methods and participant roles.

3.2.4.3.1 ***Documentation review.*** A review of six different types of documents (e.g., incident reports, communication books; see Table 2.4) found in each LTC home were completed starting three months prior to program installation (September 2011 – November 2011). The

documents were reviewed every three months for 15 months, using three tools to look for staff members' use of GPA, person-centered care skills taught in the program, and leadership characteristics (see Appendices E, F, & H). The Person-Centered Care Observation Guide described the skills and attitudes differentiating the institutional model and the person-centered approach based on the research of Kitwood (1997). The GPA Skills Observation Guide illustrated the communication skills, verbal and environmental de-escalation techniques, and steps required to support a resident and staff after a responsive behaviour has occurred. Through this research paper, the term *GPA skills* will be used to encompass the GPA skills and the person-centered care skills that are taught in the GPA program 7.5 hour training. The Leadership Observation Guide was developed based on a review of the literature on the role of leadership in sustainability of new programs. It described the skills, behaviours, and attributes of effective leaders in health care and LTC homes.

3.2.4.3.2 *Observations.* Non-participant direct observations were used to identify what GPA skills staff used when providing care to residents with dementia (particularly those who exhibit responsive behaviours) and to learn about the leadership skills that formal leaders used to help sustain the GPA program (See Appendices E, F, and H). Nurses, NAs, the CNL, kitchen staff, maintenance, formal leaders, and Recreation Therapists were observed. Direct observations were limited to the public areas (dining room, hallways, activity rooms, and seating areas) between 8:00 am and 5:00 pm (Monday to Friday). The three observation guides described above provided the framework for this data collection method. A total of 48 hours (24 hours in each home) were spent in direct observation. Direct observations helped to distinguish staff members to be shadowed over the 15 months of data collection. Shadowing is an effective way to find out what a study participant naturally does in their own work or personal setting (McDonald, 2005). Based on the direct observations, a continuum emerged of staff members whose behaviours ranged from constantly aligned with the GPA program to those whose behaviour was not aligned with GPA skills. Individuals on both ends of this continuum were interviewed first, followed by staff whose usage of the GPA program training varied. The purpose of the shadowing was to explore how and why the GPA training was used by some staff but not by others. The CNL, NAs, and Recreation Therapists were shadowed, guided by the observation tools. A total of 30 hours (15 in each home) was spent shadowing staff.

Given that the direct observations were limited to public areas; brief discussions were held with staff in circumstances where the researcher heard a responsive behaviour from a private area (e.g., resident screaming in a tub room). Additionally, when the behavior of a staff member indicated that they had just experienced a responsive behaviour (e.g., a NA rubbing a body part indicating that they had been hit), the researcher spoke with the individual to explore which GPA skills (if any) they used to help de-escalate the behaviour and whether they felt supported by their colleagues and formal leaders when using the GPA skills taught to them. NAs from both of the homes and the DOC and Recreation Therapist from Home 7 participated in the brief discussions.

3.2.4.3.3 ***Semi-structured interviews.*** Semi-structured interviews (see Appendix D) were completed with staff in both homes, using the document reviews and observation guides to guide the initial selection of interview participants. The criteria for selection of participants for the interviews was the same as the criteria for selection of staff to shadow. Additional staff members were interviewed based on theoretical sampling and the themes that emerged from the data. Once all of the categories were saturated, meaning that no additional themes emerged (Charmaz, 2006), interviews were stopped. In Home 6, the manager (interviewed twice) (*n*=2), a NA (*n*=1), a GPA Coach (*n*=1), the CNL (*n*=1), the RT (*n*=1), the ward clerk (*n*=1), and the dietary/administrative support staff (*n*=1) participated in the semi-structured interviews. In Home 7, an RN (*n*=1), NAs (*n*=2), GPA Coaches (*n*=2), RT (*n*=1), and administrative support staff (*n*=1) were interviewed. Fifteen semi-structured interviews were completed with 14 participants. See Table 2.4 for a detailed description.

3.2.5 Analytic Framework

To strengthen the findings of case study research, theoretical propositions are developed prior to data collection and analysis, based on a likely relationship between two variables (Yin, 2014). For both the retrospective and prospective studies, the primary theoretical proposition was that *facilitation leads to the sustainability of evidence-based practice.* A second theoretical proposition (rival explanation) selected a priori ensures that the researcher is collecting information relevant to their research questions and provides the researcher with data regarding other potential "influences" which may explain the findings (Yin, 2014). The rival explanation in the retrospective and prospective studies was that *leadership rather than facilitation leads to the*

sustainability of evidence-based practice. The analytic framework of both studies incorporated within-case and cross-case analyses.

3.2.5.1 Within-case analysis. An inductive, grounded theory approach based on the constant comparative method as outlined by Charmaz (2006) was used to analyze the data from each home individually (five homes from the retrospective study and two homes in the prospective study). The first step in the within-case data analysis was to code each data collection method (e.g., interviews, focus groups, documents) individually and then over time (e.g., the codes from resident 1 chart in Home 6 collected in December 2011 versus codes from resident 1 chart in Home 6 in March 2012). Secondly, codes from the same data collection method were compared to similar codes from the same home (e.g., codes from resident 1 chart in Home 6 to codes from resident 3 chart in Home 6). Thirdly, the codes from the different data analysis methods were compared to the other data collection methods (e.g., codes from the interviews in Home 6 versus the codes from the focus groups in Home 6).

3.2.5.2 Cross-case analysis. Three general strategies were used in the analysis of the data from the two studies: explanation building, pattern-matching, and cross-case synthesis (Yin, 2014). Explanation building occurs when a researcher iteratively relates the findings from the first case to the initial theoretical propositions and subsequently comparing the data to the next case, to build an explanation of how and why certain events occur (Yin, 2014). Pattern matching is the process of making a connection between a theoretical pattern (e.g., strong leadership leads to sustainability) and an observed pattern in the data. The more the patterns match, the greater the support for the propositions outlined at the beginning of the research (Trochim, 1989). Cross-case synthesis requires comparing the findings or the overall patterns from each case to the other cases in the study. Thus, the five cases in the retrospective study were compared to each other and the two cases from the prospective study were compared to each other.

3.2.5.3 Overall conclusions. The final step in data analysis was to draw conclusions from the combined findings of the retrospective and prospective studies. An interpretive pattern matching approach was used, guided by the research questions regarding the relationship between facilitation and sustainability, and leadership and sustainability, of evidence-based practices.

3.2.6 Trustworthiness

A number of strategies as outlined by Lincoln and Guba (1985) were used by the researcher in both studies to establish trustworthiness. To provide evidence of credibility, prolonged engagement (spending approximately 15 months in each of the prospective homes), persistent observation (24 hours spent observing and 15 hours shadowing staff members in each home in the prospective study), peer debriefing, and two types of triangulation (source and method) were used (Lincoln & Guba, 1985). In case study research, multiple methods are used to understand how or why certain events observed within their own environment happen or are related (Yin, 2014). Data from semi-structured interviews, focus groups, documentation reviews, shadowing, and direct observation allowed for multiple lines of inquiry, supporting stronger and more accurate conclusions and thereby enhancing credibility and overall trustworthiness. Thick description (Lincoln & Guba, 1985) was used to provide evidence for transferability and an inquiry audit (Lincoln & Guba, 1985) was completed with a doctoral committee member for dependability and credibility. Additionally, the researcher met with her supervisor and the committee member monthly to discuss and examine the data analysis process. To strengthen the findings of this research, an audit trail of raw data, coding categories, memos, field journal, and reflexive journal were kept and reviewed with the researcher's doctoral supervisor approximately every two weeks during the data collection and analysis phase (Lincoln & Guba, 1985).

3.2.7 Ethical Considerations

This research study was approved by a university research ethics board, as well as the health region ethics coordinator. All seven LTC homes provided consent prior to the beginning of data collection. The study participants gave written consent (or verbal consent if a telephone interview was completed) before the semi-structured interviews or focus groups were completed (see Appendix C). Staff members were asked if they could be shadowed or would be interested in participating in a brief discussion by the researcher. They were advised that if they did not feel comfortable with being shadowed or having a brief discussion with the researcher that they did not have to participate with no risk to their employment status.

3.3 Findings

3.3.1 Sustainability of the GPA Program

This study pointed to the importance of both facilitation and leadership in sustainability the GPA program, but leadership was identified as the key factor influencing sustainability. The

results related to facilitation will be reported elsewhere. A major finding within the retrospective and prospective studies as identified in all sources of data was that *there was variability across the homes in terms of sustainability of the GPA program*, with a continuum of low, medium, and high sustainability homes in both studies.

3.3.1.1 Low sustainability homes. In the low sustainability homes, there was little to no sustainability of the GPA program. One low sustainability home emerged from the retrospective study and one low sustainability home from the prospective study, which supported the comparison of difference design logic (lower sustainability in the independently owned and operated home with the NAs in the GPA Coach role and less management structure). In the low sustainability homes, few staff members were using the GPA skills (as identified in the direct observations, shadowing, and documentation reviews) and an overwhelming majority of the participants in the focus groups and the semi-structured interviews identified that they did not believe the program was sustained in their home. During the focus group in the low sustainability home from the retrospective study, participants were asked if they had noticed a change in whether staff members were providing care based on resident choice and resident decisions. Examples of response included*:* "Nothing has changed. Not a thing," "Nothing at all," "Nope.*"* A registered nurse from the same home made the following statement about the sustainability of the GPA program:

> *Nothing has changed in this home. Nothing. We weren't allowed to make the changes. There were ideas…huge ideas…but nothing happened. We weren't allowed to change.*

3.3.1.2 Medium sustainability homes. In the medium sustainability homes, there was a higher degree of sustainability of the GPA program than the low sustainability homes. Three homes (all from the retrospective study) were in the middle of this continuum and were classified as medium sustainability homes. There were considerably more staff members using the GPA skills (identified through direct observation, shadowing, and the documentation review) in medium sustainability homes as compared to the low sustainability homes. There was a lack of agreement among participants in the semi-structured interviews and focus groups about whether the program was sustained in their home. For example, when the GPA Coach from a medium sustainability home was asked if the GPA program was being used by staff she replied:

> *In some ways, in some ways not. A few staff will explain to the residents what they are trying to do in terms of care, but many are still being forced into bed when they don't*

want to go. We should not be telling them when they want to go to bed, they should just leave them and let them go when they want to go

3.3.1.3 High sustainability homes. On the other end of the continuum, two homes (one emerging from the retrospective study and one supporting the comparison of a difference design logic from the prospective study), were considered as high sustainability homes. The majority of the staff members were using the GPA skills on a regular basis (based on direct observations, shadowing, and documentation reviews). In the semi-structured interviews and focus groups, most participants agreed that the GPA program was sustained in their homes. For example, a chart note in the high sustainability home (prospective study) identified that a resident was struggling to settle at bed time. The staff felt that he had pain. The team held a care conference and devised a plan based on family suggestions of what this resident did prior to bed when he lived at home (e.g., rubbing his feet, offering a drink of hot water). The following is a chart note entry approximately one week after the care conference:

Resident moaning and calling out. Writer asked if he was in pain. He indicated he was. Writer provided Mr. R with analgesic, and massaged his feet with lotion and talked about his family. Resident settled. No further moaning or calling noted.

3.3.2 Leadership Characteristics Leading to Sustainability of the GPA Program

The overall finding of the current study indicates that the characteristics of the formal leaders are connected to the culture and the sustainability of the GPA program. The characteristics of the formal leaders created a culture in which the GPA program is either sustained or not. This section highlights the formal leadership characteristics that impact the sustainability (or lack of sustainability) of the GPA program.

3.3.2.1 Overview of leadership characteristics leading to sustainability. Across the low, medium, and high sustainability homes, *sustainability of the GPA program was found to be strongly influenced by characteristics (skills, behaviours, and attributes) of the formal leaders.* More specifically, lower sustainability homes had leaders with characteristics that negatively impacted the sustainability of the GPA program. In the medium sustainability homes, formal leaders displayed more positive than negative leadership characteristics compared to the leaders in the low sustainability homes, but they were not as frequently used or as high in quality as the leaders in the high sustainability homes. In the high sustainability homes, positive leadership characteristics influenced the sustainability of the GPA program. In both the retrospective and

prospective studies, poor leadership characteristics were associated with little to or no sustainability of the GPA program skills and positive leadership characteristics were associated with a higher degree of sustainability in the two high sustainability homes. The leadership characteristics are discussed below and in more detail in Table 3.1. Table 3.2 provides further details on formal leadership attributes influencing sustainability of the GPA program.

Six leadership characteristics were identified as influencing sustainability of the GPA program: shaping behaviours, relationship development, problem solving, team-building, communication style, and evaluation of the GPA program. Each of these characteristics had a range of impact from negatively affecting sustainability (in the low sustainability homes) to positively influencing the sustainability in the high sustainability homes.

3.3.2.2 Low sustainability homes. In the low sustainability homes, the leadership team negatively shaped behaviours in ways that supported the continued practice of institutional care (e.g., forcing staff members to wake residents up for breakfast at 7:30 am), displayed relationship-ruining behaviors (e.g., abusive to some staff members and showing favouritism to others), team-breaking skills (e.g., establishing a hierarchy between departments), communication approaches based on fear and punishment (e.g., threatening to have staff fired if they disobeyed their orders) and no evaluation of the GPA program. The leaders in the two low sustainability homes allowed staff members to force care upon residents and did not intervene when they physically restrained residents to complete care. Staff were not allowed to help co-workers from other departments because "they had their own job to do" and the professional staff (nurses and Recreational Therapists) were held in higher esteem than the NAs or kitchen staff. Leaders in the low sustainability home were viewed as intimidating, spent little time in the LTC home (one leader in the prospective study), and staff felt uncomfortable with approaching them with problems or issues. Although the leadership in the retrospective LTC home attended the GPA training, they did not support it.

There was a change in the DOC in one of the low sustainability homes (prospective study) that provided a contrast in leadership characteristics. Although the new DOC was only in the LTC home for 4 months during data collection, she was described as being "an angel sent from above." She displayed many of the same characteristics as the leaders in the high sustainability home, but she was not trained in GPA as the administrator did not allow her to attend. Her nursing philosophy was centred in person-centered care and she tried to help staff to

provide it, but the administrator told her that her job was "to manage staff" and "keep the building running." Her influence on sustainability of the GPA program was difficult to gauge because she was new to the home, and had expressed in a brief discussion with the first author that she had so much to learn and many tasks to complete that the former DOC had not done.

3.3.2.3 Medium sustainability homes. The formal leaders in the three medium sustainability homes attempted to positively shape the behaviours of the staff so that the care that they provided to residents was based on resident choice. They attended the GPA training and encouraged staff to practice GPA skills and be flexible in their care routines. The formal leaders coached the staff when a responsive behaviour occurred when they were on the floor (which was infrequently). The leaders in the medium sustainability homes also displayed relationship-ruining characteristics (like the leaders in the low sustainability homes), however, they also displayed some relationship-building characteristics (like the leaders in the high sustainability homes). Relationship-ruining skills included providing inconsistent feedback, not knowing the residents in the LTC home (only one leader in one home), being out of touch with staff and staffing issues that should be addressed so they did not escalate in the future (i.e., not being aware of staff members isolating other staff for practicing GPA skills). In terms of relationship-building skills, the formal leaders in two of the medium sustainability homes would help on the floor when asked by staff (but not of their own accord) and were familiar with the residents who lived in their LTC homes. Leaders in the medium sustainability homes were described as patient, calm, and caring but sometime aloof.

3.3.2.4 High sustainability homes. In the two high sustainability homes, leaders displayed more characteristics that were higher in caliber and used more frequently than leaders in the medium and low sustainability homes. The strength of the formal leaders in the high sustainability homes was the fact that the skills and behaviours that they displayed were based on shaping positive behaviours and establishing strong relationships with the staff and residents. The main message that formal leaders communicated to all staff was that they were *all expected to practice GPA skills to improve the quality of life of the residents.* Their actions supported this message. To shape behaviours and build relationships, the leaders gave staff permission to practice GPA and removed barriers that occurred when staff were struggling to do so. They role-modelled, coached, were on the floor on a regular basis helping staff to manage responsive behaviours, and gave feedback in the moment, not just at the yearly performance appraisal.

Leaders met daily with their staff to review issues that were occurring in the home (not just related to behaviours), asked for feedback on their own approach, and knew both staff and the residents well. These leaders also showed problem-solving, team-building, communication, and evaluation (of the GPA program) skills.

Table 3.1

Comparison of the Formal Leadership Characteristics Influencing Sustainability in Rural LTC Homes

Leadership Characteristics	Low Sustainability Homes	Medium Sustainability Homes	High Sustainability Homes
Shaping Behaviours	Encouraged institutional model of care Did not holding staff accountable Allowed staff to force care Did not enforce policies/procedures	Encouraged staff to practice GPA skills Expressed that care will not be forced Role modeled GPA skills Displayed critical thinking Coached Reviewed successes Gave permission to be creative and flexible Consulted outside experts to help with behaviours	Expected staff to practice GPA skills Addressed problem behaviours Role models GPA skills Gave permission to be creative and flexible Gave permission to spend time with residents Encouraged staff to coach co-workers who need help with GPA Coached staff to use GPA Addressed staff performance issues when required Provided positive feedback Reflected on practice issues with staff and held them accountable Provided staff with expectations related to the GPA program
Relationship Ruining Behaviours	Favoritism Abusive to staff Not at work/no awareness of issues Punished staff Bullied staff Unreliable	Provided inconsistent feedback Only aware of “bigger issues” in home Not always on floor Did not know residents	

Table 3.1 Continued

Leadership Characteristics	Low Sustainability Homes	Medium Sustainability Homes	High Sustainability Homes
Relationship Building Behaviours		Helped on floor when asked Recognized good work Knew the residents	Provided immediate and specific feedback Met daily with staff Aware of what was happening in home Helped on floor Listened to staff Acknowledged feelings of staff Asked for feedback Knew staff and residents Understood viewpoints of staff
Problem Solving Skills	Some problem solving around care routines	Sometimes facilitated problem solving when on floor	Led discussions on problem solving with behaviours Found ways to overcome obstacles Suggested different interventions to manage behaviours Found ways to overcome obstacles
Team Breaking Skills	Established hierarchy between staff and departments Did not set boundaries	Choose not to solve larger departmental conflicts when made aware	
Team Building Skills		Fewer interdepartmental conflicts Tried to seek some staff feedback about issues in the home	Promoted collaboration between departments Involved all staff in problem solving Sought input into decisions, processes De-escalated conflict
Communication Style	Directive Harsh	More frequent positive messages Communication only about "larger issues"	Communicated regularly with staff about changes Promoted communication between staff Expressed expectation about GPA to staff
Evaluation of the GPA Program	No evaluation of the GPA program	Very limited evaluation of GPA skills	Reassessed care plans/interventions Evaluated culture of the home

Table 3.2

Comparison of the Formal Leadership Attributes Influencing Sustainability in Rural LTC Homes

Low Sustainability Homes Leadership Attributes	Medium Sustainability Homes Leadership Attributes	High Sustainability Homes Leadership Attributes
First Director of Care and Administrator*	Patient	Patient
	Calm	Calm
	Kind	Kind
Unreliable	Gentle	Gentle
Unpredictable	Caring	Caring
Intimidating	Sometime aloof	Non-judgmental
Gruff		Positive
Judgmental		Compassionate
Unapproachable		Honest
		Tireless
		Reliable
Second Director of Care*		Supportive
		Approachable
Patient		
Calm		
Gentle		
Caring		
Non-judgmental		
Positive		
Enthusiastic		

*There was a change in Director of Care in the Prospective Low Sustainability Home

3.3.3 Relationship Between Leadership, Culture, and Sustainability of the GPA Program

Based on all of the data collection methods, a finding from the retrospective and prospective studies was that *the culture of care in the LTC homes that the formal leaders created through specific leadership characteristics influenced the sustainability of the GPA program.* The characteristics of the leaders in the seven homes created a continuum of cultures ranging from institutional to person-centered, that influenced the sustainability of the GPA program. Within these cultures, a picture of organizational functioning (ranging from maladaptive to dynamic) emerged from the data, based on whether or not GPA was accepted by the leaders and how responsive behaviours were managed by staff resulting in sustainability (or lack of sustainability). The culture of care (which is created by the characteristics of the formal leader) influenced the sustainability of the GPA program. See Table 3.3 for a more detailed description.

The more institutional the culture of care within the LTC home, the lower the sustainability of the GPA program. Conversely, the more person-centered the culture of the LTC home was, the higher the sustainability of the GPA program.

Table 3.3

Culture of Care Created by Formal Leaders Influencing Sustainability in Rural LTC Homes

Low Sustainability Homes Institutional Culture of Care	Medium Sustainability Homes Institutional Culture of Care	High Sustainability Homes Person-Centered Culture of Care
Organizational Functioning Within the Culture of Care		
Maladaptive	Transitioning	Dynamic
Few staff members were practicing GPA skills	More staff used the GPA skills	Most staff practiced the GPA skills
Fear of retribution for practicing GPA skills	Staff were looking for "official permission" from the CNL to practice GPA to avoid being bullied	Staff were expected to practice GPA skills
Fear of formal leaders	No fear of formal leaders	No fear of formal leaders
Formal leaders were not approachable	Formal leaders were approachable	Formal leaders were approachable
A large number of negative opinion leaders with a large span of influence	Fewer negative opinion leaders but still had a large span of influence	Very few negative opinion leaders with a smaller span of influence
Staff members who used the GPA skills were isolated, ridiculed, and intimidated by negative opinion leaders	Staff members who used the GPA skills were isolated, ridiculed, and intimidated by negative opinion leaders	Staff members who used the GPA skills did not receive assistance with care for residents from negative opinion leaders
Influence of negative opinion leaders and behaviours were supported by the formal leadership	Influence of negative opinion leaders and their behaviours were not addressed by formal leader unless it became a significant problem	Influence of negative opinion leaders and their behaviours were addressed by formal leaders
	Some of the formal leaders were not always aware of conflicts, ethical issues in home	Formal leaders were aware of the conflicts, ethical issues in the homes – they were managed by the formal leaders
Interdepartmental conflicts	Interdepartmental conflicts	Departments worked together

Table 3.3 Continued

Low Sustainability Homes Institutional Culture of Care	Medium Sustainability Homes Institutional Culture of Care	High Sustainability Homes Person-Centered Culture of Care
Acceptance of the GPA Program by the Formal Leaders		
Lack of dedication to the GPA Program	Dedication to the GPA Program	Dedication to the GPA Program
Did not attend GPA training in the prospective LTC home	Attended the GPA training	Attended the GPA training
Viewed the GPA Program as "one more thing" to do	Verbally supported the GPA program, but actions did not reflect their statements	Expected staff to use the GPA skills in their daily practice and actions reflected their statements
Management of Responsive Behaviours		
Medication management was the standard practice in managing responsive behaviours	Medication management of responsive behaviours were trialed first. Non-pharmacological interventions were inconsistently attempted	Non-pharmacological interventions were the standard practice in managing responsive behaviours
Triggers to responsive behaviours rarely identified by staff	Triggers to responsive behaviours inconsistently identified by staff Communication about triggers to responsive behaviour inconsistent by staff	Triggers to responsive behaviours regularly identified by staff Communication about triggers to responsive behaviours consistent between staff Consistency in following non-pharmacological interventions consistent between staff Inconsistent evaluation of non-pharmacological interventions by staff
Physical restraints used with residents with responsive behaviours		No physical restraints used with residents with responsive behaviours

3.3.3.1 Low sustainability homes.

3.3.3.1.1 ***Skills and behaviours of leaders in low sustainability homes.*** The leaders in the low sustainability homes, who tended to have skills and behaviours that were authoritarian (sometimes bordering on abusive) and who established a hierarchy based on power over others, created a culture that was based on the institutional model of care. Within these two homes, there was maladaptive organizational functioning of leadership and the staff. Overall, there was conflict between departments, and most staff members were afraid of the formal leaders. Staff would not perform tasks that were not "approved of" by management (those that were focused on tasks and routines versus based on resident choice) for fear of retribution. One NA described an incident where she was "written up" and almost fired for not complying with an order from management.

> *Our home is impeccably clean...very clean. So, what they do is....on one day a week, each wing...so that is three days a week....they close off the wings with the steel doors, right after breakfast...and the residents are not allowed to go back to their rooms until they have cleaned that entire area. I was supposed to comply with that and I was supposed to be on board with all of them. When I saw what it did to them [residents]...how it confused them. I said "Leave those doors open. Let them go to their rooms." Management said that what I did caused a safety issue…it escalated to me being written up and escalated to them calling labour relations in. I was very close to losing my job (NA, low sustainability home, retrospective study).*

Other staff members expressed that this type of incident was not an isolated event and they "had learned" to "get used to it because that is the way it is."

Within these two homes, there was a significant amount of inter-departmental conflict. Most of these conflicts were over issues that would improve the quality of life of the residents. The leaders in these two homes tended to support the departments that were proposing ideas where order, routine, and cleanliness were the most important rather than the direct caregivers (NAs and nurses) who were advocating for the residents. The same NA above described an incident where she tried to help a resident to go to her room for a nap in the afternoon.

> *When talking to labour relations, I said, "Do I have to check with housekeeping whether I can put a person to bed?" Basically, management said yes. And I thought "that is all wrong. It is me caregiving for that resident. If that resident needs something, I should be*

able to judge that, not some housekeeper." But see, they are in tight with housekeeping, so they want them to be elevated. Who is suffering here? Not me, but my resident is. And that is where I see GPA falling down all together. We do not have support. When we think a resident has a need and we implement it against their policy, we do not have support for that (NA, low sustainability home, retrospective study).

The leaders in the two low sustainability homes did not support the GPA program. The leaders in the prospective study home did not attend the initial GPA training course while the leaders in the retrospective did, however, the leaders in the low sustainability homes did not consider this program a priority. It was viewed as "one more thing to do" in a list of other initiatives that the health region was mandating. After the first GPA training session within the retrospective low sustainability home, the GPA Coaches and participants held a brain storming session to make changes to the LTC home physical environment so that there would be areas within the home that could be used by residents with dementia (e.g., reminiscence area and snack area). They created an action plan, budget, and assigned different duties to staff members to get the ideas off the ground. Staff at this training session were excited and enthusiastic about the changes that they could make for their residents. When they approached the formal leaders, it was "shot down because it wasn't feasible" and would be "too much work" for other members within the LTC home (i.e., maintenance, housekeeping, and dietary). According to an RN in this low sustainability home, *"We had all sorts of ideas. We had it all laid out kinda thing. All excited. Everybody was all pumped. Then we called in the leaders. And then it just kinda got shot down. I heard GPA sessions after this did not go well. One was stopped early because of the conflict in the room."* Once the ideas were dismissed, staff members stated that the enthusiasm and creativity that the GPA program and Coaches inspired in the staff died, along with the GPA program. Staff members continued to provide institutionalized care because it was how the leadership wanted things done.

Within the institutional model culture of care in the low sustainability homes, management of responsive behaviours was not in alignment with the GPA program. The GPA course taught staff to identify the reasons behind a behaviour and create a care plan to help minimize the behaviours. Within these two homes, non-pharmacological management of responsive behaviours was not the usual practice of the staff. Instead, residents were more likely to be physically restrained and medication management used to manage the behaviours. Triggers

to the behaviours were rarely identified, and if they were, anti-psychotic or anti-anxiety medications were used first. For example, in the low sustainability home in the prospective study, a resident was found in a female co-resident room. The next day, the nursing staff left a note in the physician's order book. *"Please review Mr. C. as there has been an increase in wandering and inappropriate behaviours to residents."* At the next physician's rounds, a prescription for Ativan was given to manage the behaviours. A week later, the following chart note was left by a nurse *"…resident disruptive. Smirking at writer. Writer ignored behaviour, on doctor's list for intervention to subdue this behaviour."* As a result, an antipsychotic medication was started. There was no trigger identified to the wandering behaviours and staff did not explore other medical, physical, or emotional issues that may be causing these behaviours to occur. The anti-psychotic was increased over 6 months and a second one was added one month prior to the end of the study. In the same home, a staff member was observed restraining a resident who was constantly urinating in co-resident rooms. She placed the resident in a reclining chair with a lap table because they did not have enough staff members to watch him or clean up after him. Another resident was given an anti-anxiety medication to help manage aggressive behaviours when staff were not able to transfer him to the toilet.

3.3.3.1.2 ***Low sustainability homes negative opinion leaders.*** Within this study, an unexpected finding related to sustainability of the GPA program was the impact of opinion leaders within the home who did not agree in the philosophy of the GPA program. These "negative opinion leaders" were identified in all of the homes in this study and their influence on sustainability differed across the continuum of sustainability. Table 3.4 provides a detailed description of the negative opinion leader characteristics in the low, medium, and high sustainability homes.

In the low sustainability homes, negative opinion leaders reported that the GPA program did not help to minimize the responsive behaviours displayed by residents with dementia and would ridicule, isolate, or intimidate staff members who tried to use the GPA skills. These incidents were described by participants as occurring frequently by numerous staff members within the low sustainability homes. The negative opinion leaders were described in the following ways: task-focused, routine, "set in their ways," and working in LTC for the pay cheque. Within the low sustainability homes, the leaders allowed the negative opinion leaders to continue with their behaviour and staff who did practice GPA were reprimanded.

Staff who believed in the benefits of the GPA program reported that they were afraid to work with the negative opinion leaders as they did not want to be targeted by them for "going against" these individuals. As a result, the staff who believed in the benefits of the GPA program provided care in a way that was institutional, routine, and task-focused when working with negative opinion leaders. In these instances, the staff member had to witness the escalation of the behaviour and watch the resident get hurt, or they, themselves were injured. These staff members indicated that having to be a part of these incidents caused them to have internal distress and to eventually disengage from the residents to protect themselves. The Recreational Therapist from the low sustainability home in the prospective study identified that the staff who tried to be flexible, spend time with residents, and practice GPA were "eaten alive" by the staff members who did not agree with the philosophy of the GPA program. To manage the impact of the negative opinion leaders, most staff members remained silent about the negative opinion leaders, or developed partnerships with other staff members to provide support. Staff members remained quiet so they did "not rock the boat."

Table 3.4

Comparison of the Characteristics of Negative Opinion Leaders in Rural LTC Homes

Characteristics of Negative Opinion Leaders	Low Sustainability Homes	Medium Sustainability Homes	High Sustainability Homes
Philosophy of Care	Task-focused Routine based Good care is clean care	Task-focused Routine based Good care is clean care	Task-focused Routine based Good care is clean care
Approach with Residents	Ignored residents Labelled residents In a hurry Forced care on residents Argued with residents Verbally/physically abusive to residents	Ignored residents Labelled residents In a hurry Forced care on residents Argued with residents	Ignored residents Labelled residents In a hurry
Approach to Job and Co-workers	Controlling Ridiculed, isolated, and intimidated staff who used GPA skills Job is a means to a pay cheque	Controlling Ridiculed, isolated, and intimidated staff who used GPA skills Job is a means to a pay cheque	Degraded the GPA program Refused to help co-workers who used GPA skills Worked in LTC because of the residents
Approach to Responsive Behaviours	Responsive behaviours are viewed as manipulative Requested medication for management of responsive behaviours Escalated responsive behaviours Punished residents with responsive behaviours	Responsive behaviours are viewed as manipulative Requested medication for management of responsive behaviours Escalated responsive behaviours	Responsive behaviours are viewed as manipulative Escalated responsive behaviours

3.3.3.2 Medium sustainability homes.

3.3.3.2.1 ***Skills and behaviours of leaders in medium sustainability homes.*** The culture of care created by the leaders in the medium sustainability homes had many of the characteristics of the institutional model of care; however, there were more staff who were using GPA skills as compared to the low sustainability homes. The managers, administrators, and DOCs in the medium sustainability homes did not lead from a place of overt power. They were more approachable but had less awareness of how staff were practicing in their homes. The organizational functioning was transitional, as the leadership and clinical practice of some of the staff had changed as compared to the low sustainability homes, but they had not reached the same organizational functioning as the high sustainability homes. The organizational functioning in the medium sustainability homes was likely due to the fact that the staff did not experience outright fear for practicing the GPA skills. There was still some departmental conflict, particularly between NAs and other departments regarding the change of the LTC homes' routines. Some of the NAs wanted to provide residents with a "relaxed breakfast" so that they did not have to get up at 7:30 AM to eat. However, the kitchen staff refused to change times because it would interfere with getting lunch ready on time. Most of the leaders in the home chose not to solve the larger departmental conflicts when they were made aware of it.

The formal leaders in the medium sustainability homes showed more dedication to the GPA program than the leaders in the low sustainability homes. These leaders verbally supported the GPA program and attended the initial training session, but their actions did not reflect their statements. Participants reported that their leaders "only paid lip service" to the program or that the leaders "talked the talk" but had difficulty "walking the walk." The leaders encouraged people to use the GPA and person-centre care skills, but they were not on the floor as often to coach and role model as the leaders in the high sustainability home were.

3.3.3.2.2 ***Medium sustainability homes negative opinion leaders.*** There were fewer negative opinion leaders in the medium sustainability homes as compared to the low sustainability homes. The negative opinion leaders intimidated, ridiculed, and ignored staff members who tried to use the GPA skills. Staff who were trying to move away from institutional care would speak to their leader or the CNL about these negative opinion leaders. Unfortunately, the CNL was not in a position to provide official job-related performance appraisals for the negative opinion leaders. Staff who practiced GPA stated that if they had permission from the CNL to use the GPA skills,

that they would *have an official reason to change practice to <u>hopefully</u> minimize the behaviours of the negative opinion leaders*. According to the CNL in the medium sustainability home in the retrospective study:

> *A big problem here, again, is the culture, right? There's, there's some staff that aren't allowed to try anything new because they get jumped on by other staff. So, a lot of them look to me for that prescription because then it is official. It came from the clinical lead. So that is allowed. You know, and it's final. It's not the way that I want it to be but that's, that's how it is. It doesn't always work, though (CNL, medium sustainability home, retrospective study).*

Besides seeking permission from the CNL, other staff members preferred to stay quiet about the negative opinion leaders as "they have to work with these staff members regularly" or because "nothing would be done about it." Staff members and GPA Coaches reported that they would offer to complete care on their own for the resident so that the negative opinion leader would not escalate the responsive behaviours. Additionally, they explained that they would (a) prioritize care needs that could be done when they were working with other co-workers who used the GPA skills and (b) only complete care tasks that were deemed as "essential" by the staff when working with the negative opinion leaders. Examples of this included changing the incontinent product of resident when they had feces on their clothing, body, or in public areas of the LTC home. When this occurred, the co-workers reported that they did most of the care and asked the negative opinion leaders to help by handing them the supplies needed to complete the task. The formal leaders only addressed the negative opinion leaders when, (a) they were made aware of the behaviours of these individuals (this did not happen often as staff members who were targeted by the negative opinion leaders did not tell their leaders because they felt "nothing would be done about it), and (b) when the behaviours of the negative opinion leaders created a significant issue.

3.3.3.3 High sustainability homes.

3.3.3.3.1 ***Skills and behaviours of leaders in high sustainability homes.*** In the high sustainability homes, the culture was person-centered and care was completed based on resident choice and preferences. The organizational functioning of the two high sustainability homes was dynamic compared to those in the low sustainability homes which had maladaptive organizational functioning. The culture in these homes was considered dynamic in that change towards person-centered care was occurring and the leaders were finding ways to improve the quality of life of

residents in their care homes. The various departments in the high sustainability LTC homes worked well together, staff members liked and respected their leadership team members, and would often seek them out to have conversations about resident and safety issues. These leaders were approachable and aware of the issues within the homes. An important finding was that not only were leaders aware of the issues or problems that were occurring within their homes (not only related to GPA, but to safety issues, or conflict between staff members or departments), leaders in the high sustainability homes removed barriers to problems that prevented staff from being able to practice GPA and other issues that were occurring in the homes. In the high sustainability home in the retrospective study, staff were concerned that information about a behavioural plan for a resident with responsive behaviours was not being communicated to all of the staff. To overcome this barrier, the leader set aside 30 minutes at the monthly staff meeting to review behavioural care plans. Additionally, this leader met with all of the evening and night staff to review the care plan for the resident with responsive behaviours and answer questions or concerns about it. Leaders in the two high sustainability homes also changed staffing complements to help NAs manage behaviours during time periods when the residents in the home became over stimulated (i.e., at shift change and at meal times), gave staff members additional coffee breaks during their day if they spent time with a resident, or assisted in recreational activities, and paid for additional staff to attend family conferences and educational in-services.

In the high sustainability homes, the main message that formal leaders communicated to all staff was that they were all *expected to practice GPA skills to improve the quality of life of the residents.* Their actions supported this message and it was not just something that the leaders verbalized (as compared to the leaders in the medium sustainability homes). The leaders in the two high sustainability homes not only attended the GPA training course, but they also spent time at the beginning of every 7.5 hour GPA training course with their staff to explain why the program was important and what they expected of their staff after attending the training. The GPA course was not viewed "as one more thing to do" but as a means to providing care to residents with dementia in a way that is person-centered, safe, and respectful of these individuals. At the GPA training, in written communication, and in meetings with staff, the leaders in the high sustainability homes sent the message that residents and their needs were at the centre of everything that the staff do.

My instruction from day one here was, yes there is paper work to do, and there is filing and all of those tasks within my job description, but when it comes to a resident, the resident always comes first. So if something ever needs to be left behind...because this particular day this one resident needs a lot of direction....one day when (name of resident) was pulling pins on the fire extinguisher and trying to keep him in his chair so he didn't fall, so I had to constantly watch.....I didn't get a whole lot of paper work done but they know that and they never....nobody ever judges that or says anything (Ward clerk, high sustainability home, prospective study).

If staff members from any department saw a resident with dementia alone, displaying a responsive behaviour, or asking for assistance (even though it was not part of that staff member's job), their first priority was to help the resident and what they were doing could wait.

Staff in the high sustainability homes relied overwhelmingly on the GPA skills and non-pharmacological interventions to help manage responsive behaviours as compared to the low and medium sustainability homes. These individuals were able to identify why a behaviour occurred (i.e., the triggers behind the responsive behaviours) and create a care plan with non-pharmacological interventions to minimize the behaviour, and in some cases to evaluate the effectiveness of the care plan. The care plans were followed with more consistency over time than the care plans in the low and medium sustainability homes. In the two high sustainability homes, there were fewer incidents of medication as the first line of treatment for responsive behaviours. When medications were used, the staff, CNL, and physician reported that they had tried every non-pharmacological intervention and a pharmacological intervention was the next step in managing the behaviours. When a medication was used, it was given for a short trial period and stopped if there were no changes in behaviours.

3.3.3.3.2 ***High sustainability homes negative opinion leaders.*** In the high sustainability homes there were fewer negative opinion leaders, who exhibited fewer and less extreme behaviours as compared to the other five LTC homes in the study. These individuals did not ridicule, isolate, or intimidate staff members who were practicing the GPA skills. Instead, these individuals would degrade the GPA program (as opposed to degrading the person using GPA skills) at team meetings, shift exchange discussions, or at coffee breaks. In the high sustainability retrospective study, the administrator reported that *"there are only a few staff members struggling with GPA, they are moving in that direction of change…but directly sabotaging it or not having*

any interest in it, I would say no." When the negative opinion leaders worked with a staff member who used the GPA skills, they would tell that person that GPA was not going to work, and either not help their partner out, or leave that person to manage the behaviour on their own. The CNL in the high sustainability home identified that *"we are down to two people who that are resisting…who will tell others this program doesn't work. But I am working with them to get them on the same side."* Interview participants identified that when the negative opinion leaders left the staff member to manage the responsive behaviour on their own, they found that they were easily able to de-escalate the situation on their own. Participants from the focus group in the high sustainability home stated that *"the few people who are more task-focused do care faster and agitate the resident. Those of us who do practice GPA…we slow the interaction right down and de-escalate it."* When the negative opinion leader stayed in the room but did not help, it took the staff member longer to de-escalate the situation.

Unlike the formal leaders in the low and medium sustainability homes, the leaders in the two high sustainability homes addressed the influence of the negative opinion leaders with respect to the GPA program. The leaders attended many of the team meetings and staff shift reports when they knew that the negative opinion leaders would be there. They invited staff to share how the GPA skills made their jobs easier. Meetings were held with the negative opinion leaders to discuss the impact of their actions. These discussions were not punitive, but were designed to gain an understanding of what was driving the actions of these individuals, and to develop a plan to help change behaviours. Coaching and role modelling sessions were coordinated with the CNL (who was also a GPA Coach) and with the NAs who were champions of the GPA program. In the prospective high sustainability home, the leader transferred two NAs (who were negative opinion leaders) to other departments that required less interaction with residents after the manager uncovered through the discussions with these individuals that they did not enjoy working with residents with dementia and responsive behaviours.

3.4 Discussion

3.4.1 Overall Sustainability of the GPA Program

The purpose of this analysis was to focus on the role that leadership played in the sustainability of new innovations or programs. Sustainability of new innovations and programs is not an easy task within health care. Partial sustainability of new evidence is more often a reality than full sustainability (Stirman et al., 2012). In LTC, sustainability of psychosocial interventions

is often challenging and chaotic (Rapaport, Livingston, Murray, Mulla, & Cooper, 2017). Interventions aimed at changing staff practice in care homes were found to be sustained for three months or more in half of the research articles reviewed by Caspar et al. (2016). Similarly there was no evidence in the literature to support sustainability of psychosocial interventions beyond six months (Rapaport et al., 2017). To provide person-centered care to residents with dementia who live in LTC homes, it is important to gain an understanding of how to implement and sustain best practice guidelines over time (Rapaport et al., 2017). This research focused on the short-term sustainability of a dementia-specific training program for staff in LTC homes over 12-15 months. Findings indicate that there was a continuum of sustainability of the GPA program across the seven LTC homes.

At one end of the continuum, two homes did not implement the GPA program and thus, did not move beyond the beginning of initial implementation phase as described by Fixsen et al. (2005). In the middle of the continuum, the three medium sustainability homes implemented parts of the GPA program to varying degrees but failed to move beyond the initial implementation stage (Fixsen et al., 2005). Specifically, there were more staff members in the medium sustainability homes who used more GPA skills in their daily practice as compared to the staff members in the two low sustainability homes. At the other end of the continuum, two high sustainability homes achieved full operation as defined by Fixsen et al. (2005) and were in the process of moving forward to innovating the GPA program within their care homes. Innovation within an organization occurs over time as the program is adapted to improve effectiveness and sustain the identified outcomes (Fixsen et al., 2005).

Unlike other studies (e.g., Caspar et al., 2016; Rapaport et al., 2017), the GPA program achieved short-term sustainability in some of the LTC homes beyond six months. Staff members in the high sustainability homes were using the GPA skills 12 to 15 months post-installation (Fixsen et al., 2005). Although a review of psychosocial intervention effectiveness in LTC homes found that most studies did not show a change in staff attitude or clinical practice (Boersma, van Weert, Lakerveld, & Dröes, 2015), the staff in the high sustainability homes in the current study displayed a change in attitude towards residents with dementia, and their clinical practice shifted to reflect the person-centered care philosophy in which the GPA program is rooted.

3.4.2 Leadership Characteristics Leading to Sustainability of Evidence-based Practices

Within LTC homes, leadership plays an important role in the sustainability of best practice guidelines (Øye et al., 2016) and in creating a culture that enables staff to provide person-centered care (Backman, Sjögren, Lindkvist, Lövheim, & Edvardsson, 2016; Brownie & Nancarrow, 2013; Lynch et al., 2018; Orellana, Manthorpe, & Moriarty, 2017). The current study found that shaping behaviours, relationship development, team-building, positive communication styles, and evaluation of the GPA program are the leadership characteristics that support sustainability of the GPA program. Some researchers have looked at the characteristics that leaders display in implementing evidence-based practices and person-centered care in LTC. Backman, Sjögren, Lindkvist, Lövheim, and Edvardsson (2017) found that highly rated care home leaders try new ideas, rely on staff the staff they supervise, coach, give feedback, and manage conflict. Similarly, open communication, relationship building, as well as problem solving and feedback have been identified as important leadership characteristics (Vogelsmeier & Scott-Cawiezell, 2011).

Researchers have also looked at the characteristics of transformational leadership styles or frameworks in health care and LTC. Engle et al. (2017) found that effective leadership is built on positive interactions with staff, empowerment of staff, and enabling staff to provide person-centered care. They found that leadership styles that are "participatory and adaptive" are important in supporting staff members to practice person-centered care (p. 323). Rokstad, Vatne, Engedal, and Selbaek (2015) reported that "transformational, situational leadership" is important in changing practice (p. 24). Based on this current research and previous research on leadership characteristics, styles, and frameworks, there is evidence that the development of *positive relationships and staff empowerment* through an interactive approach (e.g. using feedback, positive communication, role-modeling, coaching) are related to sustainability of evidence-based practices and person-centered care.

One of the most important leadership characteristics that impacted the sustainability of the GPA program in this study was the *deemed importance* of the program for staff and residents within the LTC homes. When staff members were expected to practice the GPA skills, sustainability of the program was higher. In the low sustainability homes, the GPA program was not valued by formal leadership as it was considered "one more thing to do" and therefore not sustained. In the medium sustainability homes, leaders voiced their support of the program but did not overcome the barriers to implementing the GPA program (e.g., not addressing the impact of

negative opinion leaders). The findings of this research supported the work by Rokstad et al. (2015) who found that highly professional LTC homes were able to sustain person-centered care when leaders supported staff, and the philosophy of person-centered care was interwoven in the values, beliefs, and procedures in the LTC homes. Rapaport et al. (2017) also found that when staff did not feel supported by management, they found it difficult to change how they provided care, and their team as a whole felt disempowered and lacked the ability to sustain change. This finding was supported within this study, particularly in the low sustainability homes where the leaders did not agree with the philosophy of the GPA program and failed to support staff to change their practice.

3.4.3 Culture of Care and Negative Opinion Leaders

This research shed light on LTC homes and the culture that is created as a result of the formal leadership characteristics. In the low sustainability homes, staff members described their leaders as being authoritative, powerful, and being abusive. The culture in these homes was institutional and the organizational functioning was maladaptive. In medium sustainability homes, the leaders were approachable, yet were not always aware of issues or concerns within their home. The organizational functioning was transitional and the culture was mostly institutional. These results are similar to those of Jakobsen and Sørlie (2016). They reported that when cultures created a negative atmosphere (as in the low sustainability homes), staff members reported being stressed and exhausted. Staff members described a culture where there was little trust and employees felt demoralized. “You find disharmonious cultures where the relationship between leader and care providers is characterized by distrust” (Jakobsen & Sørlie, 2016, p. 643). Engle et al. (2017) also found that negative organizational cultures had an adverse effect on staff members and their ability to provide person-centered care. In their study, staff members who worked in cultures that were authoritarian avoided providing care that was resident-directed for fear of being punished (Engle et al., 2017). This was a strong theme that was identified by staff in the low sustainability homes in the current research.

An interesting finding in the study by Jakobsen and Sørlie (2016) that was supported by the current research is that staff will chose to act in accordance with the actions (positive or negative) displayed by their leader and the type of culture that they are working in. Within the low sustainability homes, the leaders perpetuated forced care and departmental conflict, and refused to address issues related to ethical dilemmas brought to them by staff members, thereby

creating a culture of negativity and mistrust. The staff members in the low sustainability homes continued to force care on residents with dementia after the installation of the GPA program, which was in accordance with the example the formal leadership set forward. In the high sustainability homes, leaders were described as caring, supportive, and honest, with the culture being person-centered. The leaders were on the floor, helped with care, and were well respected. Staff members provided person-centered care and made time in their day to spend time with the residents outside of personal care. Jakobsen and Sørlie (2016) echoed these findings, suggesting that when leaders are visible, address ethical dilemmas and conflict, are respected, and provide feedback in ways that do not undermine staff trust, more cultural unity and collective responsibility are evident in situations that are ethically challenging.

3.4.4 Bullying in Toxic Work Environments

Within the low and medium sustainability homes, there were more individuals who held negative attitudes about the GPA program than in the high sustainability homes. These individuals were described by staff members as having a powerful force within the LTC home. In the literature on change agency, opinion leaders are those people who have informal influence over others within their organization and have an understanding of the reality behind working in health care (Locock et al., 2001). There are many research articles on positive change agents roles, facilitators, and opinion leaders, however, there are fewer that speak to the negative influence of opinion leaders (e.g., Harvey et al., 2002; Locock et al., 2001; Thompson et al., 2006). The term "negative opinion leader" was used in the current study to describe the informal influence that these staff had on the sustainability of the GPA program. Their behaviors were described by staff as "bullying." Bullying happens:

> when someone takes an action that he or she knew or reasonably ought to have known would cause that worker to be humiliated or intimidated. Bullying and harassment in the workplace can take many forms, including verbal aggression, personal attacks, and other intimidating or humiliating behaviours. (WorkSafe BC, 2013, Policy Item D3-115-2)

The behaviours of the negative opinion leaders that were reported by staff can be described as bullying. Tong, Schwendimann, and Zúñiga (2017) found that 4.6% of staff in Swiss LTC homes reported being bullied. They indicated that this number is likely low, due to sampling methods of their study and underreporting by staff. They found that a positive and understanding leader decreased the occurrence of bullying, while a leader who is unaware or unsupportive of

these behaviours can worsen and intensify the bullying. In addition, they found that lower safety culture and team cohesiveness increased bullying. These findings are supported by the current study: in the high sustainability homes, there was less workplace bullying by staff and it was subsequently addressed by the formal leaders. In some of the medium sustainability homes, the leaders were not always aware of the bullying behaviours because staff members reported that the leaders would not do anything about them or they were not on the floor enough to observe the behaviours. The formal leaders in the medium sustainability homes addressed the negative opinion leaders when they became a significant problem. In the low sustainability homes, teamwork was low, bullying was prevalent, and often displayed by the formal leadership. Tong et al. (2017) recommended training formal leaders to recognize and manage bullying in the workforce.

Within toxic work places, bullying has been reported as a factor that impacts the overall culture (Pickering, Nurenberg, & Schiamberg, 2017). Pickering et al. (2017) described the various stages that NAs go through in relation to recognizing and managing toxic work places. These stages included: learning the "toxic" environment, losing trust, reconciling expectations, and development of patient and worker safety outcomes (Pickering et al., 2017). Within the current study, staff members reported similar experiences when working in a toxic environments, particularly those staff members in the low and medium sustainability homes. For example, in the low sustainability homes, formal leaders played favourites and belittled staff members, staff members who bullied co-workers did it repetitively, and often there was more than one staff member bullying at a time. Pickering et al. identified that in toxic environments, NAs lose trust in their co-workers and formal leadership. This lack of trust was echoed by interview and focus groups participants in the low and medium sustainability homes.

To work in toxic LTC homes, Pickering et al. (2017), reported that staff members begin to develop strategies to work with negative opinion leaders and enable them to complete care for residents they work with. These strategies minimize risks to staff members' physical and emotional safety, as well as maintaining their employment (however, the needs of residents were often not first priority to maintain their own personal safety). Strategies to deal with formal leaders and co-workers who bullied included staying quiet and forming alliances (Pickering et al., 2017). These coping mechanisms were established to avoid being blamed for the incident or because staff reported that nothing would come of their reports. Staff members who experienced

bullying in the current study expressed similar reasons not bringing forward the impact of the negative opinion leaders. To provide care to residents in a toxic environment, Pickering et al. identified the following strategies: implementing workarounds, prioritizing care routines, and withdrawing from the residents. These same strategies were used by staff members in the low and medium sustainability homes in the current study.

3.4.5 Strengths and Limitations of the Research

One of the strengths of this research was the use of a multi-case study research design with both retrospective and prospective viewpoints on sustainability from homes that had implemented the GPA program 12-15 months earlier, as well as following homes that were just beginning the implementation process. The multiple sources of data collection that were used in the prospective study and the number of cases selected for both studies was also a strength. The seven LTC homes and the four data collection methods allowed the researcher to gain an understanding of sustainability of the GPA program from different participants, at different points in the implementation process, over a prolonged period of time. This study addresses the recommendation made by i-PARIHS developers (Harvey & Kitson, 2016) that prospective and longitudinal studies be conducted to improve the i-PARIHS framework over time and in different settings. Secondly, the researcher was able to observe what happens in a naturalistic setting when an intervention is being implemented, which does not happen regularly in experimental studies. These study findings can inform how we provide leadership training in LTC homes, as well as improve our understanding of what needs to happen to sustain complex interventions in these organizations.

A limitation of the study was the inability to witness interactions between staff members while they provided care to residents with responsive behaviours in private areas to gain an understanding of what happens "behind closed doors." Future studies could focus on methodologies that place the researcher as a care provider as a way to address this issue. A second limitation was related to the distance that the researcher needed to travel to the rural LTC homes. Interviews were scheduled for only one day at the five LTC homes in the retrospective study and therefore, the researcher was not able to interview all staff. Although observational research was not conducted in the retrospective LTC homes, the prospective study used multiple methods including direct observation.

3.4.6 Recommendations for Clinical Practice

It is important to provide leaders with training that focuses on leadership styles that empower staff so that they can practice person-centered care. In addition to this training, leaders should be trained in managing bullying within their organization given that workplace culture is related to safety and quality of care (Pickering et al., 2017). Findings from the current study suggest that for LTC homes, implementation models such as i-PARIHS should include the role of leadership as a key element. Within the earlier version of the PARIHS framework (Kitson et al., 1998), leadership was a sub-element under the construct of context; however, in the revised i-PARIHS framework (Harvey & Kitson, 2015a), leadership is not specifically identified as a sub-element. Rather, leadership is included more generally as a topic that needs to be considered when implementing evidence-based practices (Harvey & Kitson, 2015a). Within the i-PARIHS framework, leaders are advised to take a humanistic approach, so that staff and residents feel supported, decisions are collective, a learning environment is created, and barriers and facilitators to sustainability are in addressed and in place (Harvey & Kitson, 2015a). The current study has identified that it is important to consider leadership as playing a strong role in the implementation of training programs in LTC homes. Staff in the LTC homes in this study were strongly impacted by leadership or lack of leadership. This may be different in acute settings where managers may be more removed from the ward and interact less with the staff and patients as compared to the formal leaders in LTC homes. Thus, the i-PARIHS framework and other implementation models should reflect the importance of leadership, along with facilitation, in the implementation and sustainability of programs and innovations in LTC settings. This study found that strong leadership and strong facilitation are needed to sustain the GPA program. Leadership alone, or facilitation alone are not enough to sustain change. Leadership was found to have a larger influence over sustainability of the GPA program as compared to facilitation. Similar findings were reported by Ritchie et al. (2017) who found that strong leadership and implementation facilitation are both important in the sustainability of evidence-based practices. Specifically, they suggested that (a) without implementation facilitation and strong leadership, sustainability of programs or innovations is not likely to occur; (b) when leadership or implementation facilitation occurs alone, sustainability may occur, but the process is laborious and demanding; and (c) when both implementation facilitation and leadership happen concurrently, sustainability is highly possible.

3.4.7 Recommendations for Future Research

This study focused on how the formal leadership influenced the sustainability of the GPA program. Future research that includes the viewpoint of family members and residents with dementia is also recommended. It is of vital importance to gain an understanding of whether or not programs like GPA were sustained in the eyes of residents and families, and if GPA has also improved the quality of life of residents with dementia in LTC homes. Additionally, residents and family members may be able to highlight from their perspective what barriers and facilitators lead to the sustainability of person-centered care in LTC homes.

Future research could include quantitative measurement tools to assess the levels of person-centered care before, during, and after intervention implementation (Li & Porock, 2014). Additionally, researchers could measure the characteristics of formal leadership in LTC homes with a valid and reliable tool like the Leadership Behaviour Questionnaire which Backman et al. (2017) used to examine the specific behaviours of high functioning leaders in LTC homes. This study did not examine the leadership role of nurses in LTC homes as it related to the sustainability of the GPA program. Earlier research has suggested that supportive supervision by RNs of NAs reduces turnover in LTC homes and other NA outcomes (e.g., increase job satisfaction, better decision making, lower job stress; Bethell et al., 2018; Chu, Wodchis, & McGilton, 2014; McGilton, Chu, Shaw, Wong, & Ploeg, 2016). Additionally, researchers have recommended that newly graduated nurses receive mentoring to succeed in LTC homes as supervisors (Prentice, Boscart, McGilton, & Escrig, 2017). To further this recommendation, future research could look at providing nurses with supportive supervision training and examine the impact on the sustainability of the GPA program in LTC homes.

3.5 Conclusion

The sustainability of evidence-based practices in LTC homes is a complex and chaotic undertaking. There are many factors that will impact whether or not staff in LTC homes are able to provide quality care. The GPA program is a training course that teaches staff how providing person-centered care will decrease responsive behaviours displayed by residents with dementia in LTC homes. The characteristics of the formal leader play an important role in creating the culture of care in the LTC home, thus influencing the sustainability of the GPA program. When leadership characteristics are based on empowering care givers and creating positive relationships with staff, the culture of care is person-centered, and the formal leader supports the GPA program,

short term sustainability is achieved. Unfortunately, when the culture of care is institutional, the leadership style is top down and punitive, and negative opinion leaders are not addressed, sustainability of the GPA program is not achieved.

3.6 Linking Paper 1 and Paper 2

The i-PARIHS framework presents successful implementation (sustained use of the intervention) as a function of relationships between the elements of evidence, context, and facilitation. In the current study, the impact of facilitation on sustainability was initially the main focus. Leadership, a component of the context element of the i-PARIHS framework, was identified as a key rival hypothesis. A priori identification of potential rival explanations for study findings is an aspect of case study designs, to ensure that relevant data on alternate explanations are collected. As demonstrated in Paper 1, leadership was identified as playing a more important role in sustaining the GPA program than facilitation. Specifically, the culture created by the formal leaders in the seven rural LTC homes was a key determinant of the degree to which the GPA program was fully implemented and sustained. In homes where the culture was institutional and the formal leaders led from a place of power and fear, the GPA program was not sustained. In the homes where the culture was person-centered and the leaders built positive relationships and trust with staff, the GPA program was sustained to a higher degree.

Paper 2 describes how facilitation relates to the sustainability of the GPA program in the LTC homes in this study. Given that facilitation has been identified as the "active ingredient" in sustaining evidence-based practice, Paper 2 examined the skills, roles, and attributes of the various individuals identified in the study as conducting facilitation activities, and how these impact the sustainability of the GPA program. The implementation of the GPA program in the health region provided an opportunity to learn about the kinds of facilitation activities that occur and who is doing facilitation when no formal facilitator role is in place following the GPA training. Together, the findings of the two papers contribute to the knowledge base on implementation and sustainability of evidence-based innovations in LTC, including the need for both strong leadership and facilitation.

CHAPTER 4.0: THE ROLE OF FACILITATION IN SUSTAINABILITY OF A DEMENTIA-SPECIFIC TRAINING PROGRAM IN RURAL LONG-TERM CARE HOMES (PAPER 2)

4.1 Background

4.1.1 Health Care Providers and Recipients in Rural and Remote Areas

In 2011, the baby boom generation in Canada started turning 65 years of age. As a result, Canada witnessed the largest jump in the number of seniors over the age of 65 since 1947 (+20.0%; Statistics Canada, 2017a). Additionally, Canadians are living longer: life expectancy is now 82 years, as compared to 1871 when life expectancy was 40 years. The number of seniors (5.9 million) is currently higher than the number of children under the age of 14 years old (5.8 million; Statistics Canada, 2017a). In rural areas, the population is also aging, while younger generations are departing for urban areas (Canadian Rural Rivalization Foundation, 2015). Seniors living in smaller populated areas have different barriers to overcome than their urban counterparts. Rural seniors often lack transportation to and from urban communities for medical appointments (Bacsu et al., 2012), have a higher frequency of physical illnesses (Haggarty et al., 2010), and use more health care resources (Scott, 2000). Providing health services to rural seniors is challenging and the services provided often do not meet the needs of those who require them (World Health Organization, 2010). Changes in the external environment of the rural area (e.g. outmigration of younger people and an influx of seniors; Moazzami, 2015), government cutbacks (Forbes & Hawranik, 2012; World Health Organization, 2010), and fewer doctors and nurses (Bacsu et al., 2012; Pitblado et al., 2013; World Health Organization, 2010) are just a few of the issues that are a reality in rural areas.

Health care workers in rural and remote areas often have to be everything to everyone because there are fewer programs, practitioners, and resources available (Chipp et al., 2011; deValpine, 2014). Due to the multiple health care needs of many rural seniors, clinical practitioners, particularly nurses, need to have a wide variety of skills in this setting (Hunsberger et al., 2009; Stewart et al., 2005). However, rural nurses may not always have the skills to work with complex individuals (Daniels et al., 2007) particularly those with dementia in long term care

(LTC) homes (LaMascus et al., 2005). Given that LTC staff in rural areas have limited access to dementia specialists (Morgan et al., 2011), a sustainable in-house dementia training program that builds capacity (Grand et al., 2011) has been recommended. The purpose of this analysis was to examine the relationship between facilitation and sustainability of an evidence-based dementia training program for staff in rural LTC homes.

4.1.2 Responsive Behaviours and Dementia Training for Staff in LTC Homes

People who have been diagnosed with dementia face changes in their physical well-being, with many experiencing a change in their personality and behaviour (Alzheimer Society of Canada, 2017b). Commonly reported behavioural symptoms displayed by someone with dementia in a LTC home include agitation, verbal and physical aggression, resistance to care, and inappropriate social and sexual behaviours (Davison et al., 2017). Nurses and nursing aides (NAs) are most affected by the behavioural symptoms displayed by residents with dementia (Edward et al., 2014), with many experiencing aggression (either physical or verbal) almost daily (Banerjee et al., 2008). In this paper, behavioural symptoms are referred to as responsive behaviours in alignment with the view that these behaviours may be an expression of an unmet need or an indication of a problem in the environment for someone with dementia (Talerico & Evan, 2000). Although LTC staff work with residents with dementia on a daily basis, many report that they do not understand dementia, nor do they feel confident in their skills in managing responsive behaviours (Gates et al., 2005). To meet the learning needs of LTC staff members and to provide safe care to residents, dementia-specific training in management of responsive behaviours is needed.

4.1.3 Conceptual Framework

Realizing that there is a gap between knowledge produced and knowledge used, researchers are looking for more effective ways to improve the uptake of ideas, innovations, and programs in health care settings (Nilsen, 2015). The field of implementation science has emerged to address the challenges related to the sustainability of programs and innovations in health care organizations. Implementation science is defined as the "scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services" (Eccles & Mittman, 2006, p. 1). Evidence emerging from this research area demonstrates that in order to sustain practice change, implementation activities need to be planned and systematic in nature

(Khalil, 2016) with a focus on the patient, clinician, and the health care system (Bauer et al., 2015). The current analysis contributes to the implementation literature by focusing on the relationship of facilitation in the sustainability of an evidence-based program and the implementation context.

This research was guided by the Integrated Promoting Action on Research in Health Services Framework (i-PARIHS) developed by Kitson, Harvey, and McCormack in 1998 and revised several times (Kitson et al., 2008; Harvey & Kitson, 2015b; Rycroft-Malone et al., 2002). In the 2015 i-PARIHS revision, the concept of facilitation was highlighted as the "active ingredient" that creates change within the organization, with successful implementation resulting from "the *facilitation* of an *innovation* with the *recipients* in their (inner and outer) *context"* [emphasis added] (Harvey & Kitson, 2015b, p. 40). Innovation refers to "what" is being implemented, and recipients are the individuals or organizations who play a large role in the implementation of evidence-based practice. Context includes both the inner and outer layers of the organization. The inner context is where the program is being implemented (e.g. LTC home, hospital ward), while the outer context is the larger health care system which includes policies, procedures, and governmental laws.

Harvey and Kitson (2015a) highlight the importance of facilitation within the i-PARIHS framework. They state that facilitation is a planned and organized process. The main attributes of facilitation in the i-PARIHS framework include involving participant ownership and engagement, providing feedback, and giving the recipients the opportunity to become empowered and build capacity within the organization. Facilitation can be differentiated further by examining how "being a facilitator" differs from "doing facilitation" (Kitson & Harvey, 2015, p. 75). Being a facilitator requires an individual to be fearless, curious, and patient. "Doing facilitation" occurs when individuals develop relationships with co-workers, foster team-work, and create a learning organization. The promotion of facilitation in the 2015 i-PARIHS framework reflects growing recognition of its importance in practice change, yet there is still a gap in knowledge about which aspects of the facilitation process or role are more or less effective (Harvey et al., 2002) and how facilitation operates in various contexts (Stetler et al., 2006). Specifically, this study explored who was doing facilitation in selected rural LTC homes, how they did it, what facilitation activities occurred in the rural LTC homes, and how these factors influenced sustainability.

Kitson et al. (1998) and Harvey and Kitson (2015b) use the term *successful implementation* to reflect the continued use of evidence-based practice. Successful implementation occurs when the initial project goals have been met, the practitioners are using the innovation or skills in their daily practice, the individuals or teams feel that the innovation "belongs" to them, and the variation between organizations have been minimized (Kitson & Harvey, 2015). Sustainability is implied in the use of terms such as change, practice change, change process, uptake of knowledge, and success (Harvey et al., 2002; Harvey & Kitson, 2015b; Kitson et al., 1998; Rycroft-Malone, 2004). Sustainability will be defined here as successful implementation.

4.1.4 Research Problem and Questions

Although researchers have examined the applicability of the PARIHS framework in various settings (Brown & McCormack, 2005; Kavanagh, Watt-Watson, & Stevens, 2007), little is known about facilitation as described in the i-PARIHS framework in LTC homes. Additionally, it is not known how facilitation interacts with other factors identified in the i-PARIHS framework (i.e., recipients, context, and the nature of the innovation) that may influence sustainability of research evidence. This paper will focus specifically on the relationship between facilitation and the short term sustainability of a dementia-specific training program over a time frame of 15 months from program installation (Fixsen et al., 2005) to end of data collection. Fixsen et al. (2005) describes six implementation phases: exploration and adoption, program installation phase, initial implementation, full operation, innovation, and sustainability. The GPA program was considered fully installed into the LTC homes when all resources (i.e., selection and training of the GPA Coaches, funding to provide the GPA program to all staff in the LTC home, and space to hold the training) were secured and all staff were trained in the 7.5 hours GPA program. The research questions that were examined in this study were: 1) What is the relationship between facilitation and sustainability of training programs in rural LTC homes? What types of facilitation (roles, skills, and attributes) are associated with sustainability? 2) In what ways do the internal GPA Coaches act as facilitators during and after program implementation? How do the facilitation activities of the internal GPA Coaches compare to others who may play a facilitation role?

4.2 Methods

4.2.1 The Intervention

The Gentle Persuasive Approaches (GPA) program is an evidence-based program that is designed for staff in LTC homes. The objective of this program is to teach staff the skills to be able to identify, de-escalate, and manage responsive behaviours in a way that is safe and respectful for the residents with dementia and for staff members (Schindel Martin et al., 2005). All staff in the home receive training, including dietary and maintenance staff, NAs, nursing staff, and administration. At the time of data collection, GPA used the "train the trainer" teaching method, where two staff members per LTC home attended a two-day GPA training course taught by GPA Master Coaches to become certified as Coaches. The Coaches then taught the 7.5 hour course in their own LTC homes to all staff members.

The GPA course is based on best practice guidelines for dementia care and curriculum presentation is rooted in adult learning principles. Course content includes video clips, resident stories, role plays, and self-reflection exercises. A maximum of 12 staff members attend the 7.5 hour training course at a time. The curriculum is divided into four modules that address the topics of person-centered dementia care, brain and behaviour in individuals with dementia, interpersonal environment and communication skills, and the gentle persuasive techniques to help staff manage responsive behaviours.

4.2.2 Retrospective and Prospective Study Methods

An explanatory, holistic, multiple-case study design (seven cases) was used to study the relationship between the concepts of facilitation and sustainability of the GPA program. This research project was conducted using a *retrospective study* in five rural long-term care homes in which the GPA program had already been fully installed (Fixsen et al., 2005) and a *prospective study* that began with the program installation stage (Fixsen et al., 2005) in two rural care homes and followed events over a 15 month period. Both studies were completed in the same health region and provided two viewpoints (looking back and looking ahead) on the relationship between facilitation, leadership, and short-term sustainability. The case study method allows a researcher to study complex events by using multiple data collection and analysis strategies to gain an understanding of the phenomenon or context being studied (Yin, 2014). This method was a good fit with the gradual implementation of a dementia specific training program for staff across rural LTC homes by a health region on the Canadian Prairies.

4.2.3 Retrospective Study Design

This study was conducted using a multi-site case study research design in which the selected design logic was that of "matching" cases (Fitzgerald & Dopson, 2009). Five study cases were selected on two matching criteria: rural location and complete installation of the GPA program at the time of data collection Data were collected at one point in time after program installation, and the study participants were invited to reflect on their experiences related to facilitation and sustainability of the GPA program over the prior 12 to 15 months since they received the GPA training.

4.2.3.1 Setting and site selection. The study was conducted in a health region on the Canadian Prairies that has one large urban centre located in a large geographic area. Sixteen LTC homes in the study region were situated outside of the urban centre and were considered rural for the purposes of this study because all had fewer resources available to them than LTC homes in the urban centre in the region (e.g., behavioural consultants, geriatric psychiatrists). At the time of data collection, seven of the 16 rural homes had fully installed the GPA program, five of which were selected for the retrospective study. Two rural LTC homes were excluded because they were pilot sites for the implementation of the GPA program.

Home 1 (39 beds) was the only LTC home in this study that was owned and operated by the health region. The four remaining homes were independently owned and operated (reporting to an LTC home board and the health region). Home 1 had a full-time manager and the GPA Coaches were nursing aides (NAs). Homes 2, 3, 4, and 5 employed administrators (all were full-time with the exception of Home 5) and Directors of Care (DOCs; all were part-time with the exception of Home 4). The number of LTC beds ranged from 17 to 36. Positions of the GPA Coaches included a Registered Nurse and NA in Homes 2, 3, and 4, while the GPA Coaches in Home 5 were both NAs. The five LTC homes were located at various distances away from the large urban population centre (between 30 and 200 kms). Three of the LTC homes met Statistics Canada (2017b) definition of small population centres (1,000 – 29,999) and two met the definition of rural (<1,000 population). The LTC homes located in the small population centres were included in the retrospective study because they had access to fewer resources (e.g., psychiatrists, mental health nurses) than LTC homes located within the large urban centre and are treated as rural LTC homes by the Health Region. The homes with fewer services have not had as

much support, coaching, or mentoring from dementia specialists as those homes with more services. See Table 2.1 for characteristics of the five LTC homes.

4.2.3.2 Participants. Administrators and DOC are formal roles that are found only in LTC homes that are independently owned and operated by a private board. Registered Nurses (RNs) are those individuals within the LTC home who have a diploma or bachelor's degree in nursing and Registered Psychiatric Nurses (RPNs) are those who have a degree or diploma in psychiatric nursing. They are responsible for (but not limited to) medication administration, communication with physicians and families, and supervision of the NAs. In the health region where the research was completed, Licensed Practice Nurses (LPNs) hold a 2-year diploma in practical nursing. LPNs are often the charge nurses in the rural LTC homes and their duties may include medication administration, communication with physicians and families, and supervision of NAs. NAs provide a majority of care to residents in LTC homes. To become a certified NA, individuals are required to complete a 32-week course (total of 54 credit units); however, they have an option of completing the program within two years of employment. The curriculum includes such classes as personal care, human growth and development, and food safety. Of the 54 credit units, four credit units are focused on caring for people with dementia or working with their families. The NA students receive one credit unit for completing the Professional Assault Response Training program. Managers and Clinical Nurse Leaders (CNL) are employed only in homes owned and operated by the health region. CNLs are RNs who act as liaisons between the resident, the family, care staff, and the physician in clinical issues. They provide leadership, education, and mentoring to all staff who are involved in direct care. The CNL reports directly to the Manager but may provide direct supervision to the staff if the Manager is away. GPA Coaches are the individuals who are responsible for teaching the one-day GPA course to co-workers in their LTC care homes. In this study the GPA Coaches included RNs, NAs, and a Recreation Therapist (RT). Administrators (*n*=3), DOCs (*n*=2), managers (*n*=1), CNL (*n*=1), GPA Coaches (*n*=5), RNs (*n*=3), and NAs (*n*=16) participated in the semi-structured interviews and focus groups. See Table 2.2 for a detailed account of participants within this study.

4.2.3.3 Data collection and analysis. Data collection for this study began in February 1, 2012 and was completed by the end of January 31, 2013 (see Table 2.2 for further details).

4.2.3.3.1 ***Semi-structured interviews.*** Administrators, managers, and DOCs were classified as "formal" leaders. Their interviews were grouped together in both studies to explore

their perspective of the relationship between facilitation and sustainability of the GPA program (see Appendix D for interview guide). The GPA Coaches, nurses, and CNL were interviewed to learn about their experiences and their perspectives on factors associated with facilitation and the sustainability of the program (see Appendix D for interview guide). Formal leaders interviewed for this study included managers (*n*=1), administrators (*n*=3), DOCs (*n*=2). Direct Care staff who participated in the semi-structured interviews included GPA Coaches (*n*=5), RNs (*n*=3), CNL (*n*=1), RT (*n*=1), and NA (*n*=1). In Home 3, the two GPA Coaches were interviewed together, as were the administrator and DOC in Home 4. All interviews, with the exception of two telephone interviews (with the CNL in Home 1 and the RT in Home 4), were conducted at the LTC home and were audio recorded and transcribed verbatim by the researcher. See Table 2.2 for a detailed description of semi-structured interview participants.

4.2.3.3.2 ***Focus groups.*** NAs spend the most time providing hands on care and therefore have more exposure to responsive behaviours than other staff. To maximize the number of NAs who were able to participate, focus groups were held in four of the five homes (Table 2.2). A total of 15 NAs participated in the focus groups. In Home Four, the group had to be cancelled several times to accommodate other priorities. A third date was set but only one NA participated. She was interviewed using the focus group interview guide. The aim of the focus groups was to learn about the experiences of direct care staff with respect to the GPA program and to explore how facilitation affected their ability to apply the knowledge gained from the initial training course. All of the focus groups were held in the LTC home and were audio recorded and transcribed by the researcher. See Table 2.2, and Appendix D for interview guide used for the focus groups.

4.2.3.3.3 ***Analysis*****.** Although not aimed at developing a theory since the study was guided by the i-PARIHS framework, the retrospective study was informed by the constructivist approach to grounded theory as defined by Charmaz (2006). In the constructivist approach, analyses are viewed as mutually constructed interpretations versus facts discovered by a neutral expert observer. The data were analyzed using the constant comparative method (Charmaz, 2006). The within-case and cross-case analysis approach was the same for the retrospective and the prospective studies and will be described with the prospective study methods.

4.2.4 Prospective Study Design

The prospective study was designed to gain an understanding of the relationship between facilitation and sustainability of the GPA program over time in two rural LTC homes where the

GPA program was being installed (Fixsen et al., 2005). This study used a longitudinal, multi-case study design, in which two cases were purposely selected using the comparison of difference design logic (Fitzgerald & Dopson, 2009). In this design, cases are selected based on the prediction of contrasting results for reasons that can be anticipated. The prospective study began 6 weeks after the start of program installation and continued for 15 months post program installation.

4.2.4.1 Site selection. Between September 1, 2011 and October 31, 2011, four rural LTC homes in the region had begun to train their staff in the 7.5 hour GPA training program. Two homes (Table 2.3) were purposefully selected to maximize variation on organizational factors that may influence the implementation and sustainability of the GPA program (owner-operator model, management and reporting structure, position of the GPA coach). Difference in the owner-operator model may provide insight into how organizations prioritize their funding. Independently owned and operated homes are provided with funding from the health region but are able to choose how they spend their money, whereas, homes owned and operated by the health region are provided with a highly specific budget with little freedom on spending. Leadership structure is different in the two homes. This provides valuable information on how the presence (or not) of a formal leader may influence sustainability of the GPA program. Difference in position of the GPA Coaches may highlight how a position of an employee influences sustainability. The differences between the two homes are as follows: Home 6 had a full-time manager and a CNL whereas Home 7 had a part-time administrator and a part-time DOC (no CNL). Home 6 was owned and operated by the health region and employed a full-time manager. The GPA Coaches were the CNL and an LPN. Home 7 was independently owned and operated and reported to a private board and the health region. One home met the criteria for small population centre as defined by Statistics Canada (Home 6), while the other LTC home was located in a rural area (Home 7) (Statistics Canada, 2017b).

4.2.4.2 Participants. Study participants differed by data collection approach, and included direct care, kitchen, and recreation staff, as well as formal leaders. Managers (*n*=1), CNL (*n*=1), NAs (*n*=1), RT (*n*=1), dietary/administrative support (*n*=1), GPA Coach (*n*=1), and ward clerk (*n*=1) participated from Home 6. In Home 7, RNs (*n*=1), NAs (*n*=2), RT (*n*=1), GPA Coaches (*n*=2), and administrative support staff (*n*=1) participated in this study. See Table 2.4 for a detailed description of the participants, role, and data collection methods by LTC home.

4.2.4.3 Data collection procedures. Data collection (from December 1, 2011 to February 28, 2013) alternated between the two LTC homes in the study (Homes 6 and 7) over the 15-month study period. Two days a week were spent in each home every other week. Three methods of data collection were used: document reviews, direct observation, and semi-structured interviews (see Table 2.4).

4.2.4.3.1 ***Documentation review.*** Six types of documents found in each of the LTC homes were reviewed for the document analysis. These included incident reports, nursing communication books, physician communication books, NA communication books, 12 resident charts (6 in each home), and staff meeting minutes. Document review was conducted for three months prior to the installation of the GPA program (September 1, 2011 – November 30, 2011) and for 15 months following installation at three-month intervals. Three tools were used to guide the document review as the researcher looked for evidence of person-centered care and practice change by staff members (see Appendices E, F, & G). The Person-Centered Care Observation Guide is based on the work of Kitwood (1997). It specifies the differences in attitudes and care approaches between the institutional model and the person-centered care model of caring for someone with dementia as described in the GPA curriculum. The GPA Skills Observation Guide describes the communication and environmental de-escalation techniques to manage a responsive behaviour, as well as how to support and follow up with the resident and staff after a behaviour occurs. Within this paper, the term GPA skills will be used to incorporate the GPA and person-centered care skills that are taught in the initial 7.5 hour training program. The Facilitation Observation Guide describes the facilitation strategies identified by Dogherty et al. (2010) and Janes et al. (2009). Janes et al. (2009) identified the individual level factors of the facilitator and receiver, and contextual factors related to the internal and external organization that play a significant role in the success or failure of a facilitator in LTC.

4.2.4.3.2 ***Observation.*** Direct observations of staff from the nursing department (nurses, CNLs, NAs), kitchen and recreation staff, maintenance, and formal leaders were conducted to look for use of facilitation strategies (Dogherty et al., 2010; Janes et al., 2009). Non-participant observations were completed between 8:00 am and 5:30 pm (Monday through Friday) and occurred only in the public areas of the LTC home (e.g., the dining room, hallways, and activity room). A total of 48 hours (24 hours in each home) were spent observing staff from all departments in this study.

Direct observations also helped to identify staff members to be shadowed. Shadowing in qualitative research occurs when a researcher follows a participant in their own environment for a set period of time to learn about their individual experiences (McDonald, 2005). Direct observations and the document review identified a range of individuals whose behaviours varied from consistently being in alignment with the GPA skills and program philosophy to those whose behaviours did not align. NAs, the CNL, and Recreation Therapists were shadowed in this study. The shadowing was guided by The Person-Centered Care, GPA Skills, and Facilitation Observation Guides (see Appendices E, F, & G). A total of 30 hours (15 in each LTC home) were spent shadowing staff.

During the direct observations, because the researcher was not able to observe staff in resident rooms or private areas, she had brief discussions with the staff in situations when she heard a responsive behaviour coming from these areas (e.g., tub room) or when the NAs' behaviour indicated a responsive event had occurred (e.g., shaking their heads or rubbing body parts that indicated they may have been hit). The discussions centred on which GPA skills (if any) they used to de-escalate the situation. The researcher also asked if they felt supported by their co-workers and the formal leaders in the home to use the skills taught in the GPA program. NAs (from both homes), the DOC (Home 7), and Recreation Therapist (Home 7) participated in the brief discussions.

4.2.4.3.3 ***Semi-structured interviews.*** Findings from the document review and observations guided the initial selection of individuals to participate in a 30 to 60 minute interview, using the same criteria used to select staff for shadowing. Additional staff were selected via theoretical sampling based on the themes emerging from the data. Interviews were conducted until the theoretical categories were saturated, meaning that no new themes were emerging (Charmaz, 2006). There were staff members from across the LTC home who participated in the semi-structured interviews. From Home 6, the manager was interviewed twice (*n*=2), an NA (*n*=1), a GPA Coach (*n*=1), the CNL (*n*=1), an RT (*n*=1), the ward clerk (*n*=1), and a dietary/administrative assistant (*n*=1) were all interviewed. In Home 7, an RN (*n*=1), NAs (*n*=2), GPA Coaches (*n*=2), the RT (*n*=1), and the administrative support staff (*n*=1) agreed to be interviewed. A total of 14 staff members participated in 15 semi-structured interviews (the manager in Home 6 was interviewed twice). See Table 2.4 for further details on semi-structured interview participants and Appendix D for semi-structured interview guides.

4.2.5 Analytic Framework

Case study research designs, including the data to be collected and analysis strategies, are guided by a priori theoretical propositions about expected relationships between study variables (Yin, 2014). The theoretical proposition that guided the data analysis for the retrospective and prospective studies was that *facilitation leads to the sustainability of evidence-based practice.* Additionally, a priori specification of rival explanations ensures that relevant data are collected (Yin, 2014). The rival explanation examined in the current study was that *leadership rather than facilitation, leads to the sustainability of evidence-based practice.* The analytic framework for both studies included within-case and cross-case analysis. This paper reports on the findings related to facilitation.

4.2.5.1 Within-case analysis. The data for each of the five retrospective homes and the two prospective homes were each analyzed individually as a case using an inductive, grounded approach with the constant comparative method (Charmaz, 2006).

4.2.5.2 Cross-case analysis. Three specific analytic techniques were used in the cross-case analysis in both studies: explanation building, pattern-matching, and cross-case synthesis (Yin, 2014). Explanation building is an iterative process of comparing findings from the first case to the initial theoretical proposition, then comparing the evidence from the next case, to gradually build an explanation about how and why events occur (Yin, 2014). The cross-case synthesis involved comparing the findings (overall patterns) from each case to other cases in the study (Yin, 2014). Thus, the five cases were compared against each other in the retrospective study and the two cases were compared against each other in the prospective study.

4.2.5.3 Overall conclusions. The final step of the analysis was to derive conclusions or inferences from the combined findings of the retrospective and prospective studies. An interpretive pattern-matching approach was used to compare the pattern of findings between the two studies, keeping in mind the core research question of relationships between facilitation and sustainability. The rival explanation was also examined by exploring the relationship between leadership and sustainability.

4.2.6 Trustworthiness

Trustworthiness was addressed for both studies by various strategies as identified in Lincoln and Guba (1985). Prolonged engagement (15 months for the prospective study), persistent observation (24 hours observing and 15 hours shadowing in each home in the

prospective study), source and method triangulation, and peer debriefing were used to strengthen credibility. Transferability was accomplished through thick description, which occurs when the researcher collects data about the context that is rich and detailed (Stake, 2006). An inquiry audit (Lincoln & Guba, 1985) was completed for dependability and credibility with a doctoral committee member. The researcher met with this individual and her doctoral supervisor monthly to review the data analysis process. An audit trail (Lincoln & Guba, 1985) was also kept by the researcher (raw data, data charts, coding categories, memos, field journal and reflexive journal) and was reviewed with the researcher's doctoral supervisor every two weeks during data collection and analysis phase.

4.2.7 Ethical Considerations

Approval for this research was granted by a university-affiliated research ethics board and the health region ethics coordinator. Consent was sought from each individual LTC home prior to the start of the research. Written consent or verbal consent (for telephone interviews) was obtained prior to the semi-structured interviews and focus groups (See Appendix C).

4.3 Findings

4.3.1 Categories of Sustainability of the GPA Program

A major finding of this study was that *there was variability across the homes in terms of sustainability of the GPA program, with a continuum of low, medium, and high sustainability homes* based on the semi-structured interviews, focus groups, direct observations, and document reviews from the retrospective and prospective studies.

4.3.1.1 Low sustainability homes. On one end of the continuum there were two homes in which there was little to no sustainability of the GPA program. One home from the retrospective study emerged as having low sustainability and one home from the prospective study supported the comparison of a difference design logic (lower sustainability in the owned and operated homes with NAs as GPA Coaches and less management). There were very few staff using the GPA skills (as observed in the direct observations, shadowing, and documentation reviews). An overwhelming majority of the staff members in the semi-structured interviews and focus groups indicated that they did not feel the GPA program was sustained in their homes.

4.3.1.2 Medium sustainability homes. There were three homes that emerged from the retrospective study as having a higher degree of sustainability than the two low sustainability homes. These homes were in the middle of the sustainability continuum and they were considered

medium sustainability homes because there were more staff members displaying the GPA skills as compared to the low sustainability homes. There was inconsistent agreement between staff members (in the semi-structured interviews and focus groups) on whether or not the GPA program was sustained in the LTC homes.

4.3.1.3 High sustainability homes. On the furthest end of the continuum, one LTC home emerged from the retrospective study and one home supported the comparison of a difference design logic in the prospective study as being high sustainability homes. Most of the staff in these two homes were using the GPA skills in their daily practice (based on direct observations, shadowing, and documentation reviews) as compared to the medium and low sustainability homes. In the semi-structured interviews and focus groups, most staff identified that the GPA program was sustained in their LTC homes.

4.3.2 Informal Facilitators Influencing Sustainability of the GPA Program

The proposition that guided this research was that *facilitation leads to the sustainability of evidence-based practice.* Facilitation was observed in all of the homes to varying degrees. Facilitators in each of the homes were grouped into either informal or formal facilitator groups.

4.3.2.1 Skills and behaviours of informal facilitators related to sustainability. Individuals across the LTC homes who facilitated the use of GPA were termed informal facilitators as they were not in a formal facilitator role. Informal facilitation happened in all of the homes to varying degrees. Informal facilitators were mostly NAs but recreation, dietary, and housekeeping staff were also observed using facilitation skills or were noted by participants in the interviews. In all seven homes, informal facilitators role modelled, provided support, and coached in relation to the GPA program. Informal facilitators role modelled in the following ways: meeting resident needs, advocating for person-centered care, spending time with residents outside of care routines, knowing the residents, and being flexible with care. In the high sustainability home from the prospective study, a NA trained her three dogs to become therapy dogs so that she could bring them to the LTC home when she was not at work. She identified that three residents had dogs on the farm growing up and she wanted them to be able to experience being with animals again. Providing support included doing tasks outside of job description, listening to co-workers, and validating co-workers' feelings. The ward clerk from the high sustainability home noticed that a new LPN was having a bad day and perceived her to be sad. *"I approached the LPN and asked her if she would like to talk. She started to cry because she was nervous working*

in LTC and was not sure she was going to be accepted by staff. At the end of our discussion, she felt better. It didn't take long…to talk." Coaching consisted of reminding co-workers to use the GPA skills and teaching staff in the moment.

Within the medium and high sustainability homes, the informal facilitators were *doing more and higher quality facilitation than in low sustainability homes*. Skills or behaviours displayed by the informal facilitators in the medium and high sustainability homes included fostering team dynamics, knowledge exchange, critical reflection, communicating and evaluating behavioural interventions, and problem solving. Fostering team dynamics consisted of managing conflict; knowledge exchange included teaching about dementia, and interpreting and explaining responsive behaviours to co-workers; supporting critical reflection involved asking staff to reflect and examine their own approach with residents; evaluation and communication of behavioural interventions occurred when informal facilitators verbally communicated reasons related to the success or failure of behavioural interventions; and problem solving included identifying and discussing behavioural triggers and interventions. The same ward clerk as above was asked if she felt her ability to think creatively and think outside of the box influenced others. She stated:

> *I made an activity apron for one of our residents because she was always tearing apart things. She loved it! She fiddles with it all the time. Her husband was almost in tears because she had something to do…that made me really happy. We identified as a team that this resident was bored. She was a house-wife and needed something to do. My co-workers are now coming up to me with other ideas for residents. We have created lap blankets and fiddle muffs for our residents.*

In the high sustainability homes, the informal facilitators displayed more characteristics and behaviours in the areas of fostering team dynamics and evaluating and communication of behavioural interventions. They went beyond managing conflict (an example of fostering team dynamics) and they stood up against bullying between staff and asked for feedback on their own approach to managing responsive behaviours. Additionally, they provided written communication in the resident care plan and progress notes on the potential success or failure of behavioural interventions for the resident with responsive behaviours. An example of fostering team dynamics and providing support occurred when a dietary staff from a high sustainability home came back on her day off to help the NAs with the Easter Celebration because they were short staffed. She boiled eggs at her own home, and helped the residents color them. She facilitated a discussion

with the residents on what Easter celebrations were like on the farm so that the NAs could finish their jobs and the residents would not have to miss out on a celebration.

In the low sustainability homes, the facilitators were limited by the leadership in terms of performing higher facilitation skills. The leaders in the low sustainability home did not support the GPA program and therefore, the informal facilitators were only able to role-model, provide support, and coach. In the medium sustainability homes, the formal leaders verbally supported the GPA program and the informal facilitators were able to perform higher quality facilitation skills as compared to the informal facilitators in the low sustainability homes. In the high sustainability homes, the leaders expected all staff members to practice the GPA skills and the informal facilitators were able to perform additional skills based on the culture of the home and the acceptability of the GPA program.

4.3.2.2 Attributes of informal facilitators related to sustainability. Across the seven LTC homes, three categories of attributes displayed by the informal facilitators emerged from the data in relation to sustainability: (1) personality traits, (2) approach to the job and interactions with co-workers, and (3) interactions with residents. Personality traits of the informal facilitators that were identified in all homes included being credible, respected by co-workers, positive at work, and caring toward residents. There was some variability in the approach to the job and interactions with co-workers by informal facilitators. In all seven homes informal facilitators were passionate, practiced the GPA skills, and enjoyed their jobs. In the medium and high sustainability homes, informal facilitators were described as team players who were supportive and flexible. The approach of informal facilitators towards residents who displayed responsive behaviours was consistent across all seven of the LTC homes. These individuals were described as being calm, patient, friendly, and gentle towards not only residents who displayed responsive behaviours but to all of the residents within the LTC home. The DOC from a medium sustainability home (retrospective study) described her head cook as someone who "lives and breathes" GPA at home and at work:

> *(Name of head cook) is truly a GPA model because she truly understands what the residents with dementia are feeling and she goes above and beyond. If you were to come watch her work every morning, she just interacts with the residents…finds out how their day is going…just her attitude…positive being…she is caring, trusting, and respectful.*

Everything she does is for them…engaging them the entire day (DOC, medium sustainability home, retrospective study).

4.3.2.3 GPA coaches as facilitators influencing sustainability. This section will review the influences of the GPA Coaches, excluding the CNL who was a GPA Coach in Home 6. The skills of the CNLs are reviewed elsewhere in this paper.

4.3.2.3.1 *GPA coach skills influencing sustainability.* Although not a formal expectation of the GPA program, the Coaches provided facilitation in varying degrees in the seven LTC homes after program installation. All of the GPA Coaches problem-solved, coached, and role modelled. Problem-solving consisted of brain-storming with staff members around interventions and triggers to responsive behaviours; coaching involved teaching in the moment and showing or suggesting different approaches to managing responsive behaviours; and role-modelling included practicing the GPA skills every day and spending time with residents outside of the care routine. A GPA Coach in a low sustainability home in the retrospective study exhibited change management skills that were not identified in other GPA Coaches in the six other homes (with the exception of the CNL/GPA Coach in the prospective study high sustainability home). The GPA Coach led the participants through a "brain storming session" after the first GPA course because it had sparked an interest in participants to improve the quality of life of the residents in their LTC home. However, the leadership disagreed with their plan, thus leaving the participants feeling defeated and the program was viewed as "one more thing to do" by staff members.

In the high and medium sustainability homes, GPA Coaches provided support to their co-workers, fostered team-work, and monitored the use of the GPA and person-centered skills. Providing support to staff occurred when GPA Coaches communicated the successes of the GPA skills and gave positive feedback to staff in the moment about their approach to responsive behaviours. GPA Coaches fostered teamwork by addressing the negativity directed to the GPA program by staff members and mediated conflicts between co-workers. GPA Coaches in the medium sustainability homes monitored which staff members were using GPA in their daily practice, but did not evaluate staff members (the GPA Coaches in the high sustainability homes did). A CNL from a medium sustainability home described how a GPA Coach role modelled person-centered care behaviours when a resident was crying and could not be consoled:

(Name of GPA Coach) will just take that time to sit down, hold her hand...you know, demonstrate by example, find out where she is at in her world and meet her there… I see

afterwards, others are slowing down, doing the same thing. Rather than "Oh, (resident's name), you know, it's ok, we will be right back" and running by (CNL, Medium Sustainability Home, Retrospective Study).

In the high sustainability homes, the GPA Coaches displayed additional skills in the categories of providing support, fostering team-work, and evaluating the use of GPA in the LTC homes. These individuals helped staff on the floor when they required assistance (providing support), celebrated successes with staff (fostering team-work), and evaluated staff use of the GPA program. These findings suggest that there is more and better facilitation in the high sustainability homes because of the formal leadership. The formal leaders created a culture that supported the GPA Coaches to do higher quality facilitation.

4.3.2.3.2 ***Barriers to facilitation for GPA coaches.*** In all of the homes, the shift pattern, workload of the GPA Coaches, and lack of financial reimbursement were barriers that affected their ability to work closely with staff to help them change their practice. Some of the GPA Coaches only worked during the day and were not available to help evening and night shift staff members. In the prospective study, the CNL was a GPA Coach and it was difficult for her to provide support to staff to use GPA skills because she split her time between the LTC home and the hospital. She was frequently pulled away from the LTC home on her scheduled days because the hospital was short staffed or needed her expertise in the emergency department. Workload was an issue because being a GPA Coach was not separate from their regular jobs, thus Coaches were not always able to take the extra time to help their co-workers. Coaches also suggested they could not do more facilitation because they were not paid for it and therefore should not take time away from their regular jobs.

In the low and medium sustainability homes the GPA Coaches who were NAs were not as respected as those GPA Coaches who were an RN, RT, or CNL. Study participants highlighted the fact that GPA Coaches should be individuals who are respected within the organization (e.g., individuals who have worked many years in the home and who work well with residents and co-workers) and have credibility (e.g., individuals who have "proven themselves" by helping other staff or by being dependable). A GPA Coach (employed as a NA) in a retrospective study medium sustainability home described why the other GPA Coach (also employed as a NA) in the home was able to work more closely with other NAs on using the GPA skills than she was:

(Name of GPA Coach) has been here the longest, so, ya, that one goes over pretty good. With myself, I have only been here for the three years, so. Like, ya...it's ok, but you do get that look, that, ok, what do you know because you have only been here for three years, I have been here for thirty-five...right? And there is a lot of older staff that have been here for thirty-five years... And you know, twenty-five years, so you are not going to be able to tell them nothing (GPA Coach, medium sustainability home, retrospective study).

In the low and medium sustainability homes, GPA Coaches explained that they did not have the power or authority in their position to do more facilitation because they were not in a supervisory role. As a result, they were limited to problem solving, role modelling, and/or coaching. They reported that if they "commanded," "asked," or "provided direct feedback about approach" that they would be viewed as a "know it all." A GPA Coach (who was a NA) expressed what would happen if she did more than provide staff members with a suggestion or role modelled for her co-workers:

Because I would be that, "....oh, she thinks that she knows everything" and I have to work with everyone. I can show by example...and I think that I have....I think I do....I try.... But I don't think that I could go up and tell somebody, "...don't do that." I could try, "do you think maybe we could try this...." or "maybe that's not working because...." But I would...the people I would have to say it to would be the ones that (inaudible)....condemning....and I have big shoulders, but it's a long time to work that way (NA, medium sustainability home, retrospective study).

Similarly to the GPA Coaches, study participants reported that in order for staff to change their practice, someone who had more authority within the LTC home should be the person who was working directly with them on the floor as opposed to the GPA Coaches who were NAs. They expressed that it was appropriate for the NAs to teach the course, but an RN, CNL, or DOC in the Coach role was a better choice in terms of changing how staff cared for people with responsive behaviours. An RN in a retrospective study medium sustainability home suggested that "…*for reinforcing, I think that, it does have to come from, ah, higher up."*

Conflict between GPA Coaches and co-workers impacted the sustainability of the GPA program in three of the LTC homes (two low sustainability homes and one medium sustainability home). When co-workers reported that they were being scolded or being "forced to change," they would not accept help or support from the GPA Coach. In a low sustainability home an argument

broke out in the second GPA training course because the GPA Coach reprimanded participants for not believing in the program and recommended that they not work in the LTC home. Management was called in to mediate and the course ended early. Study participants who were at the initial training course identified that this incident "lead to the GPA program backfiring" (DOC, Low Sustainability Home, Retrospective Study) and it "blew GPA out of the water." The participants in the second low sustainability home identified that one of the GPA Coaches in the low sustainability home was "very directive" and "forceful" with staff and residents. Because this Coach was in constant conflict with fellow employees the staff were not able to see the value of the program.

4.3.3 Formal Facilitators Influencing Sustainability of the GPA Program

4.3.3.1 Clinical Nurse Leaders as facilitators influencing sustainability. Within the seven homes, there were two CNLs who acted as facilitators (one in a medium sustainability home within the retrospective study, and one in the prospective study high sustainability home). Nine skills emerged from the data that described the facilitation skills displayed by the CNLs. Many of the skills that the CNLs displayed were focused more on enabling staff members as opposed to being task focused. Enabling skills included problem solving, critical reflection, shaping behaviours, relationship building, effective communication, change management, and fostering team-work. Task focused skills focused on the assessment and evaluation of the GPA program, and knowledge translation. See Table 4.1 for a detailed description of these skills.

4.3.3.2 Clinical Nurse Leader skills influencing sustainability. The most important skills identified by staff that influenced the use of GPA and person-centered care skills by staff were critical reflection, shaping behaviours, relationship building, and fostering team-work. Critical reflection focused on getting staff to examine their own approach on working with residents with dementia who displayed responsive behaviours and then challenging staff to do things differently with that resident to become more successful. Shaping behaviours of the CNL included mentoring staff, providing immediate feedback, giving staff the permission to be flexible in how they provided care, explaining the GPA skills to staff members, and role modelling the GPA skills in their own daily practice. To build relationships with the staff and residents, the CNL was available to help with care and was visible within the LTC home. Additionally, she instilled confidence in the staff and completed tasks that were outside of her job description.

The CNL in the high sustainability home from the prospective study went outside of her job description when she spoke with a family member about a resident who was diagnosed with depression and dementia. She asked them what would make their mother feel “alive” again and they suggested that their mother loved farm animals. The CNL arranged for a local farmer to bring in animals (and build a fenced in area for them) for the summer so that the residents could go and feed them. The care plan for this resident reflected that when she was sad, staff were to take her outside to be with the animals. More than one resident benefitted from this intervention and staff members observed the power of creativity and how providing person-centered care can improve quality of life for residents diagnosed with dementia and depression.

Table 4.1

Enabling and Task Focused Skills and Behaviours of Clinical Nurse Leaders in the Medium and High Sustainability Homes Influencing the Sustainability of the GPA Program

Enabling Skills/Behaviours		
Problem Solving	Effective Communication	Fostering Team-work
Focuses on prevention of behaviors	Explains expectations related to the GPA program	Establishes positive work environment
Brain storming on triggers and interventions	Explains reasons for moving to GPA	Mediates conflicts with staff
Critical Reflection	Shaping Behaviours	Relationship Building
Gets staff to examine their own approach	Mentors staff	On the floor
Challenges staff to do things differently	Provides feedback	Provides safe place for discussions
Change Management	Utilizes external supports	Instills confidence in staff
Leads/facilitates organization change	Gives staff permission to be flexible	Listens to staff
Sparks enthusiasm for program	Coaches staff	Follows through with tasks
	Explains GPA skills	Goes beyond job description
	Role models GPA skills	Teaches staff to de-personalize behaviours
		Willing to apologize and accept feedback
Task Focused Skills/Behaviours		
Knowledge Translation	Assessment and Evaluation	
Educates staff about dementia	Meets daily with staff to review issues/day to day functioning	
Provides staff with educational materials	Completes chart audits	
Uses technology	Advocates for reduction in anti-psychotic medications	
	Keeps staff accountable for following care plans	
	Links resident outcomes to GPA usage	
	Completes performance appraisals	

4.3.3.3 Clinical Nurse Leader Attributes Influencing Sustainability. Attributes of the CNLs in both homes were very similar and are described in Table 4.2. Attributes that positively impacted the sustainability were those of credibility, authority, and respect. Several staff members explained that the CNLs were respected and credible because they had a higher education, had "proved themselves" to the staff by helping them out when they were short staffed, and were involved in the day to day activities in the LTC home. The CNLs had authority because they were in a "hybrid" role of leader and facilitator (i.e., displayed leadership skills, had some authority, and had facilitation skills). As a result of the credibility, respect, and authority, staff were more receptive to using the GPA program in their daily work as compared to the GPA Coaches who had less authority and power within the LTC home.

> *I think one of the reasons the GPA program has worked so well is because our CNL is someone who gets it, who understands that there is a need for it, and ah, she promotes it. Staff respond to her because that is her role. Right and it's expected of her. Which is the difference between the GPA Coaches and her. Right? Because with the GPA Coaches, it's not really their role, like part of their job (Manager, medium sustainability home, retrospective study).*

Table 4.2

Attributes of Clinical Nurse Leaders in the Medium and High Sustainability Homes Influencing Sustainability of the GPA Program

Attributes of CNLs Influencing Sustainability of the GPA Program		
Patient	Non-judgmental	Persistent
Calm	Encouraging	Respected
Funny	Creative	Enthusiastic
Knowledgeable	Dependable	

4.3.4 Culture of Care

Although not the focus of this paper (these results will be discussed in further detail elsewhere), formal leaders were influential in the sustainability of the GPA program in the seven LTC homes. The formal leaders in the high sustainability homes displayed more advanced facilitation and leadership skills than leaders in the medium and low sustainability homes. The

cultures that were created by the formal leaders ranged along a continuum from institutional to person-centered. In the homes in which the culture of care was mostly institutional, there was little to no sustainability of the GPA program (low sustainability homes). Conversely on the opposing end of the continuum, in the LTC homes where the culture was based on person-centered care philosophy there was a high degree of sustainability of the GPA program (high sustainability homes).

4.4 Discussion

4.4.1 Overall Sustainability of the GPA Program

Sustainability of an innovation or program is difficult to achieve, particularly in a complex environment like an LTC home. Partial sustainability of an innovation, program, or idea is often reported in studies (Stirman et al., 2012). A review of practice change interventions in LTC homes found that improvements were sustained three months or more in only half of the studies (Caspar et al., 2016). In the current study there was a continuum of sustainability of the GPA program. Two of the seven LTC homes (low sustainability homes) – one from the prospective study and one from the retrospective study – failed to implement the GPA skills and did not move beyond the beginning of the initial implementation stage as defined by Fixsen et al. (2005). Three homes (medium sustainability homes from the retrospective study) implemented some of the GPA skills but had not moved beyond initial implementation (Fixsen et al., 2005). A higher number of staff in the medium sustainability homes were using more GPA skills than staff members in the low sustainability homes. Two homes (high sustainability) achieved full operation and were moved towards innovating the GPA program within their LTC homes (Fixsen et al., 2005). Within this study, the GPA program was being used by staff in LTC homes beyond three months as identified by Caspar et al. (2016). The GPA program was still sustained at 12 to 15 months after installation in high sustainability homes. Additionally, this study found that there was a shift in attitude and practice change within medium and high sustainability homes that is not in alignment with the findings of Boersma et al. (2015). They found that in a review of psychosocial intervention effectiveness in LTC homes, a significant change in attitude or skill set of staff members was not achieved in a majority of the studies (Boersma et al., 2015).

4.4.2 Facilitation as a Means to Sustainability of the GPA Program in LTC Homes

A major finding within this research is that facilitation occurred in all of homes within this study. Informal facilitators, GPA Coaches, formal leaders (in the medium and high sustainability

homes) and the CNLs (in the medium and high sustainability homes) were doing facilitation within the LTC homes. This finding is in alignment with the i-PARIHS framework in that many people, both in formal positions of facilitation like the CNL, and informal facilitators can function as facilitators (Harvey & Lynch, 2017; Kitson & Harvey, 2015). Informal facilitators in all of the homes role modelled, provided support, and coached staff members in addition to being calm, patient, and gentle. In the medium and high sustainability homes, the informal facilitators fostered team dynamics, critical thinking, and knowledge exchange while the informal facilitators in the low sustainability homes did not. In terms of attributes, the informal facilitators in all seven homes were credible, respected, and caring. A possible reason why the attributes were the same across all of the homes was likely due to the fact that the informal facilitators were the individuals who practiced the GPA skills prior to the installation of the program. The implementation of the GPA program gave the informal facilitators official permission from their leadership to practice the skills taught in the GPA program.

Informal facilitation occurred and was necessary, but on its own was not sufficient to sustain the GPA program. Informal facilitators did not do more than suggest or show staff members how to manage responsive behaviours because they were not in a position of authority and did not want to be perceived as a person who knows more than their co-workers. For informal facilitators to have a greater influence on the sustainability of the GPA program, they need to be supported to practice the GPA skills by the formal leaders within the home. Support from the formal leaders includes role modelling the GPA program when the formal leaders are on the floor, advocating and creating an environment where staff are not punished or bullied when they practice GPA, and coaching/mentoring staff who are not practicing GPA. When staff members, including the informal facilitators and GPA Coaches observe their leaders practicing and supporting GPA, as well expecting that staff practice GPA, the program is more likely to be sustained (Boersma et al., 2015; Colón-Emeric et al., 2015; Fleiszer et al., 2015a; Kaasalainen et al., 2015).

GPA Coaches in all of the homes exhibited facilitation skills even though facilitation after program installation was not an expectation of this role. GPA Coaches like the informal facilitators, coached and role modelled in all of the LTC homes. Unlike the informal facilitators, GPA Coaches problem-solved in all of the homes. In the medium and high sustainability homes, GPA Coaches provided support (which was a skill displayed by informal facilitators in all

homes), and they monitored and evaluated (high sustainability homes only) staff members' use of the GPA skills. However, the GPA Coach role as defined at the time of data collection was not sufficient to sustain the GPA program by itself. Including facilitation as an official part of the GPA Coach role after the initial training program has been delivered (and providing appropriate training and support for this role) would address the gap in ongoing support for LTC staff in integrating the GPA skills in their daily practice.

Similar to the informal facilitators, GPA Coaches needed to be in a position of authority (e.g., CNL or LPN) in order to create change in practice. Staff in the GPA Coach role (besides the CNL and the LPN as GPA Coaches in the high sustainability prospective home) did not feel that they could provide additional coaching because they were not viewed as "officially having a position" to provide facilitation beyond feedback and coaching. When homes are selecting staff members for the GPA Coach role, they should consider staff members who are in a position of authority with credibility and respect from staff (e.g., Manager, CNL, or RN/LPN/RPN). GPA Coaches need to be financially compensated and trained in facilitation, and ideally a GPA Coach should be on each shift to help staff change their practice. The GPA program is a complex innovation requiring a shift in how staff provide care when working with residents who display responsive behaviours. Thus, it is important that when a program like the GPA is being implemented, only one innovation is being focused on at a time (Higuchi et al., 2017). Additionally, the workload demands of the Coaches, informal facilitators, and others should be managed so that they have the time to work with staff on using the GPA skills within their daily practice.

4.4.3 Importance of a Formal Facilitator Role in the Sustainability of the GPA Program in LTC Homes

A CNL is a position that is unique to the rural LTC homes that are owned and operated by the Health Region in this study. CNLs are expected to play a leadership role within the LTC homes and acute care sites in relation to clinical guidance, client care, and education for staff. They are also required to participate in policy development and quality improvement issues. CNLs work closely with families, physicians, and residents/patients in relation to clinical, medical, or quality of life issues. Within this study, the CNL role was a "hybrid" role of leader (in a position of authority) and facilitator (i.e. facilitation skills such as shaping behaviours, relationship building, problem-solving, and fostering team-work). CNLs in a position of authority

who also had credibility, were respected, and had effective facilitation skills and the attributes needed to support staff, had a positive influence on the sustainability of the GPA program. These findings were supported by Grealish, Henderson, Quero, Phillips, and Surawski (2015), and Kaasalainen et al. (2015), who found that clinical educators, Nurse Practitioners (NPs), and Clinical Nurse Specialists (CNS) had an impact on the sustainability of programs and the creation of a learning culture in LTC homes. Kaasalainen et al. (2015) concluded that the CNSs and NPs within LTC homes are ideal champions to help implement and sustain evidence-based practices. The duties performed by the CNL in this study were similar to those of the CNS and clinical educators as described by Grealish et al. (2015) and Kaasalainen et al. (2015), including educating staff, using audits and feedback, following up with staff related to their use of the innovation, and establishing positive relationships with staff. The CNL in the medium sustainability retrospective home had strong facilitation skills. However, the leadership in this home was weaker than in the high sustainability home (prospective study). Thus, the work of the CNL was not supported, which limited her effectiveness and the sustainability of the program.

Leadership is an important factor in the sustainability of programs or innovations because formal leaders create the culture within their home that that enables staff to provide care that is based on resident choice (Brownie & Nancarrow, 2013; Lynch et al., 2018; Øye et al., 2016). These findings were supported in the related study of the role of leadership in sustainability of the GPA program in rural LTC homes (Chapter 3, Paper 1). The researchers identified that *the culture of care that the formal leaders created through specific characteristics influenced the sustainability of the GPA program.*

4.4.4 The Role of Facilitation and Leadership in Sustaining the GPA Program in LTC Homes

The current research suggests that the GPA program is more likely to be sustained when there are informal facilitators, GPA Coaches are deemed formal facilitators for the program, other formal facilitators (i.e., CNL) with the appropriate skills and attributes for the context, combined with strong leadership (from those in formal leadership roles such as DOC or Manager) with strong facilitation skills are present in the LTC home. These results support the findings of Ritchie et al. (2017) who concluded that implementation facilitation and strong leadership work in collaboration to sustain evidence-based practices. Ritchie et al. argued that (a) without both implementation facilitation and leadership, innovation sustainability is highly improbable; (b)

when either leadership or facilitation (completed by facilitators in a designated position of facilitator) is present on its own, sustainability is possible but would be arduous; and (c) when facilitation and strong leadership are present together, sustainability is highly probable. Ritchie et al. suggested that strong facilitation may be important to create change in organizations where there is weak leadership, and recommended further research to explore the relationship between implementation facilitation and leadership. Although informal facilitation was not examined in their study, it is an important component of facilitation and sustainability that should not be over looked.

4.4.5 Future Research and Considerations

Sustainability is a complex and multifaceted concept that can be studied from many different aspects ranging from facilitators of and barriers to sustainability, to the examination of various types of sustainability outcomes. Future research should focus on the role that external facilitators play within the sustainability of complex interventions in LTC homes. An appointed external facilitator may have led to greater sustainability of the GPA program within the rural LTC homes. It is important for the sustainability of a program for staff in LTC homes, that a formal implementation leader be appointed so that it does not become viewed as "one more thing to do," particularly when the culture of the home may need to change. In a review of psychosocial intervention implementation literature in LTC homes, Boersma et al. (2015) recommended that a project leader directly responsible for the intervention would improve the likelihood of sustainability. They also recommended using multiple strategies to reinforce new skills in ways that are flexible for staff members to participate in (e.g., different training times and training methods).

As suggested by Harvey and Lynch (2017), facilitation is a labour intensive and costly intervention for organizations. It is not clear what frequency and intensity of facilitation is needed in LTC homes. Further studies are needed to discover if greater amounts of facilitation create results that are financially sustainable. Finally, in the absence of a formal facilitator role associated with the GPA program, this research focused on the informal facilitators who work in LTC homes. Additional research needs to centre on delineating the roles of opinion leaders, champions, and advocates in facilitating change in LTC homes. Since the i-PARIHS framework was re-conceptualized by Harvey and Kitson in 2015, there have been few studies that focus on refinement of the concept of facilitation.

4.4.6 Strengths and Limitations of the Research

A significant strength of this research is the number of cases and the multiple data collection methods that were used to study the relationship between facilitation and sustainability in LTC homes. Seven cases were selected, and three types of data collection strategies were used for triangulation. This study addresses the recommendation from Harvey and Kitson (2016) that prospective and longitudinal studies be conducted to examine and enhance the i-PARIHS framework. Specifically, they recommended that (a) prospective studies be used to further develop the i-PARIHS framework as a diagnostic and evaluative tool in implementation research and (b) that comprehensive longitudinal studies be conducted to understand and assess the function of facilitation and facilitators as an avenue to create practice change. The prospective study followed the implementation of the GPA program over 15 months from program installation to full operation and heading to the innovation phases (in the high sustainability home).

Given the travel distances to the rural study homes, interviews for the retrospective study (five homes) were scheduled at one point in time and only staff scheduled to work that day were available to be interviewed. Conducting observations in the retrospective LTC homes would have provided further data that would either confirm or disconfirm the subjective experiences of the interview and focus group participants. The researcher was not able to view interactions between care staff and residents in private areas of the LTC home such as bedrooms and bathrooms. Future studies that place the researcher as directly participating in care as an NA (e.g. ethnography) may shed light on how NAs use the GPA skills during personal care and bathing.

4.5 Conclusion

The purpose of this research was to learn about the relationship between facilitation and sustainability of the GPA program in seven rural LTC homes, using a retrospective and prospective lens. Study findings suggest that sustaining a program that is as complex as the GPA program requires informal facilitators, GPA Coaches, and a CNL (or similar role) in a position of authority with credibility, in addition to a leadership team that builds a culture that is person-centered, and supports and models the GPA program skills in their daily practice. A main reason for the success of the GPA program in the prospective high sustainability home was due to the presence of a CNL. Although the CNL in the medium sustainability home was limited in her effectiveness because the leadership in this home was weaker, both CNLs did more facilitation

that was higher in quality than the informal facilitators and GPA Coaches. The CNLs used skills such as critical reflection, shaping behaviours, and relationship building as ways to work with staff members in the LTC homes to use the GPA and person-centered care skills within their daily practice. For LTC homes implementing evidence-based programs or innovations, leadership should identify who their informal facilitators are, establish a facilitation team of formal facilitators including 'hybrid"-type positions like the CNL to influence the sustainability of evidence-based practice in LTC.

CHAPTER 5.0: DISCUSSION

5.1 Overview of the Findings of Papers 1 and 2

The implementation of a dementia-specific educational program in a larger health region on the Canadian prairies provided a naturalistic opportunity to learn about factors that impact the sustainability of innovations in rural LTC homes. The purpose of the previously discussed studies was to gain an understanding of two factors that research has highlighted as having an impact on the sustainability of evidence-based practices: facilitation and leadership. The first paper examined the role of formal leadership as it related to the implementation and short-term sustainability of the GPA program in seven rural LTC homes. Specifically, Paper 1 examined the characteristics that the formal leaders displayed and the culture of care that they created that enabled (or did not enable) staff members to practice the GPA skills in their rural LTC home.

The second paper focused on the skills, behaviours, and attributes of facilitators (both formal and informal) that were associated with sustainability of the GPA program. This research contributes to the implementation science literature in that two i-PARIHS constructs were studied together (versus independently) in seven rural LTC homes over a 15-month time period. These two papers together addressed a gap within the literature because researchers do not have a firm understanding of how facilitation and leadership work together to create change in rural LTC homes. Given the current movement towards person-centered care in LTC homes, it is important to sustain innovations such as the GPA program because it helps staff understand that responsive behaviours displayed by residents with dementia are as a result of an unmet need. When staff are able to identify the unmet need and provide care in a manner that is true to resident choice, responsive behaviours are likely to decrease, keeping the resident happy and staff members safe. This research will help decision makers at the organizational and larger health care setting level to identify barriers to implementation of person-centered care programs, leading to better financial, resident, and staff outcomes.

This chapter will review the findings from the two studies and apply the learnings to the larger body of literature related to facilitation, leadership, and sustainability of innovations in

rural LTC homes. It will also highlight the strengths and limitations of this research as well as the directions for future research in this area.

5.2 The Impact of Leadership and Organizational Culture on Sustainability of a Dementia-Specific Training Program in Rural Long-Term Care Homes (Paper 1)

The overarching goal of this paper was to examine the role of leadership (administrators, managers, and DOCs) in sustainability of the GPA program in seven rural LTC homes. A continuum of sustainability of the GPA program emerged across the seven LTC homes. The low sustainability homes where the formal leaders displayed negative characteristics had little to no sustainability of the GPA program, and therefore did not move beyond the beginning of the initial implementation phase (Fixsen et al., 2005). In the medium sustainability homes, where the formal leaders displayed a combination of more positive than negative leadership skills, there was higher sustainability as compared to the low sustainability homes. However, the medium sustainability homes did not move beyond the initial implementation phase (Fixsen et al., 2005). In the high sustainability homes, the formal leaders exhibited positive leadership characteristics and the GPA program was sustained. In these two homes, full operation was achieved and movement towards innovation occurred. Innovation is the phase within the implementation process where a program has become a part of the fabric of the organization and it can be adapted (as long as the core elements within the program are still intact) to strengthen the program.

Although there has been some research in the area of leadership in health care over the last two decades, there has been a paucity of research on leadership in rural LTC homes. It is important to gain an understanding of what leaders do to sustain innovations and how often they display these characteristics, and to reflect on how these characteristics impact staff members' ability to change practice in their LTC homes. This research highlighted not only what is important related to leadership characteristics in LTC, but also identified the unique aspects of leadership in rural LTC homes. The i-PARIHS framework (Harvey & Kitson, 2015a) that guided this study highlighted the importance of leadership when implementing evidence-based practice in health care settings. This research was one of the first studies to examine leadership as identified in the i-PARIHS framework. Findings from this study can inform refinement of the i-PARIHS framework to reflect the unique culture of all LTC homes.

5.2.1 Leadership Characteristics

There has been research conducted in LTC homes related to the leadership characteristics (also called skills, behaviours, and attributes within the literature), styles, and frameworks that are related to sustained interventions (Corazzini et al., 2015; Harvey & Kitson, 2015a; Lynch et al., 2018; McGillis Hall et al., 2005; McGilton et al., 2007; McGilton, 2003, 2010). As a result of this body of knowledge, it appears that leadership characteristics, styles, and frameworks (e.g., situational, humanistic) that are based on building positive relationships with staff members through supportive and empowering leadership characteristics (e.g., being empathetic, dependable) in addition to the use of interactive social processes (e.g. being on the floor, role-modelling, coaching) have an influence on sustainability. This study supports the above findings in that the leaders in the high sustainability homes displayed many of the positive relationship building characteristics, were involved in the day to day activities in the LTC home and were able to change practice through interactive strategies consistent with previous research (e.g., role modelling, coaching, positive communication strategies; Bass & Judge, 2010; Caspar et al., 2016; Davies et al., 2010; Eliopoulos, 2013; Jakobsen & Sørlie, 2016; Lundgren et al., 2016; McGillis Hall et al., 2005; Pluye et al., 2005; Rokstad et al., 2015; Stetler et al., 2014). This study did not support the findings of Øye et al. (2016) who indicated that formal leaders do not always have to involve staff members in decisions or be involved in the day to day occurrences within the organization to implement programs. As evidenced in the medium sustainability homes, leaders tended to be more removed from the LTC home and the program was not sustained to the same level as compared to the formal leaders in the high sustainability homes who had more involvement with the staff, residents, and the GPA program.

One of the most important leadership characteristics that was related to the sustainability of the GPA program was the deemed importance and support of the GPA program. In the low sustainability homes, the program was not considered a priority as it was mandated by the health region, whereas in the medium sustainability homes, leaders expressed the importance of the GPA program, but their actions (i.e., removing barriers to practicing GPA) did not reflect this. In the high sustainability homes, the leaders deemed the GPA as important and expected their staff to practice the GPA skills. The leaders implemented the person-centered care philosophy in their own daily practices, as well as in the mission, vision, values and processes within the high sustainability homes. This finding was supported by Rokstad et al. (2015), who identified highly

professional nursing homes as those where leaders supported and empowered their staff members in practicing person-centered care, and included the philosophy of resident choice in their mission, vision, and daily care process. Similarly, Cranley et al. (2018) found that leaders in high performing nursing homes who sustained quality improvement initiatives not only used positive communication strategies and developed strong teams, but they showed support for the innovation.

5.2.2 Culture of Care and Negative Opinion Leaders

A key finding in this study was that the characteristics of formal leaders created a culture of care that was either a barrier or a facilitator to the sustainability of the GPA program. This finding is consistent with previous researchers who indicated that formal leaders create the culture in their LTC homes, which influences the ability of staff to perform person-centered care (Backman et al., 2016; Brownie & Nancarrow, 2013; Lynch et al., 2018; Orellana et al., 2017). Within the low sustainability homes, leaders displayed negative leadership characteristics that created an institutional culture of care, and the GPA program was not sustained. In the medium sustainability homes, the formal leaders displayed more positive characteristics than in the low sustainability homes (as well as some negative characteristics), creating a culture that was less institutional than the low sustainability homes. In the high sustainability homes, the formal leaders created a person-centered culture of care by displaying characteristics that were positive and empowered staff.

A key finding of this research that was strongly related to the success or failure of the GPA program was the presence of negative opinion leaders. These individuals were present in each of the homes, however, the differences between the homes were: (a) the span of influence that the negative opinion leaders had over their co-workers and within the culture of the organization, (b) the number of negative opinion leaders within the home, and, (c) the frequency and intensity of the behaviours that the negative opinion leaders displayed. To further add to this finding is the fact that the stronger the institutional model of care culture in the LTC home, the stronger the influence of the negative opinion leader. Conversely, the stronger the person-centered care philosophy in the home, the lower the influence of the negative opinion leaders. Within their model of workplace bullying, Trépanier, Fernet, Austin, and Boudrias (2016) identified that leadership style and the culture of the organization is directly related to bullying. They proposed that empowering relationship building styles of leadership would decrease bullying. Additionally,

they suggested that in organizations where negative opinion leaders and their behaviours are accepted and a part of the day-to-day happenings, bullying occurs. The findings from the current research support the propositions of Trépanier et al. (2016). In the homes where the leaders supported (or ignored) the negative opinion leaders and the culture was institutional in nature, bullying was accepted. In the high sustainability homes, where the culture was positive and the leaders addressed the bullying through positive and supportive leadership qualities, bullying was minimalized. The findings from this study are also in alignment with Skehan (2015) and Tong et al. (2017) who identified that leaders must recognize bullying and then put measures in place to deal with negative opinion leaders. The finding related to negative opinion leaders indicates that just as in other countries around the world, care staff in Canada are experiencing bullying (Pickering et al., 2017; Tong et al., 2017). If staff are to provide quality care to residents in LTC homes, bullying must be managed by leadership (Skehan, 2015).

5.3 The Role of Facilitation in Sustainability of a Dementia-Specific Training Program in Rural Long-Term Care Homes (Paper 2)

5.3.1 Informal and Formal Facilitators Influencing Sustainability of the GPA Program

Within the health care setting, facilitation is a concept that has gained evidence as a method of creating practice change (Kitson et al., 1998; Harvey et al., 2002). However, in the literature related to LTC, the process and role of facilitation/facilitators is not as well understood as compared to other health care settings such as acute care. The purpose of this research was to shed some light on the process of facilitation in rural LTC homes, particularly focusing on who was doing facilitation, and what skills, behaviours, and attributes these individuals displayed when implementing a dementia-specific training program for staff in care homes. Facilitation is an important research focus, as the i-PARIHS framework describes facilitation as the "active ingredient" in sustaining evidence-based practice (Harvey & Kitson, 2015a, p.47).

In the current research, a continuum of sustainability of the GPA program (ranging from low sustainability homes to high sustainability homes) evolved out of the data. Within these homes, there are many individuals across the organization who potentially play a role in facilitation of new programs or innovations (e.g., clinical nurse educators, DOCs, clinical nurse specialists, nurse practitioners). The current research highlighted the fact that there were informal facilitators (e.g., NAs), GPA Coaches, formal facilitators (i.e., CNLs), and formal leaders with the appropriate skills, behaviours, and attributes (i.e., managers, DOCs, administrators) within the

seven LTC homes doing facilitation. Each of these groups of individuals displayed facilitation skills, behaviours, and attributes that supported the sustainability of the GPA program. Informal facilitators were identified in all seven LTC homes and a majority of the skills that they were using were similar across the homes (e.g., role modelling, providing support). In the medium and high sustainability homes, the informal facilitators displayed additional characteristics that ranged from fostering team dynamics to critical thinking. These characteristics were not found in the informal facilitators in the low sustainability homes. The reason for the limited facilitation from the informal facilitators in the seven LTC homes was that they did not want to be perceived as a "know it all" and because they were not in a position of authority within the LTC home. This finding was supported by Rapaport et al. (2017) who found one barrier to staff using psychosocial interventions was staff not wanting to be viewed as instructing their co-workers and not feeling they had the authority to do so. Based on the findings from this research, informal facilitation alone was not enough to achieve sustainability.

GPA Coaches were also using facilitation skills even though this was not a formal expectation of their role. Similar to the informal facilitators, their skills alone were not enough to sustain the GPA program. Informal facilitators and GPA Coaches must be supported by the leadership within the home to increase the likeliness of sustainability. When selecting the GPA Coach, it is important to choose individuals who are in a position of authority and are respected and have credibility amongst the staff. This is supported by the research on facilitation by Dogherty et al. (2013) who identified that authority and credibility are important skills for a facilitator. These study findings suggested that RNs, LPNs, CNLs, or NPs may be more effective as GPA Coaches in LTC homes than NAs.

The CNL role was related to the sustainability of the GPA program in this research. Other studies have identified that positions such as nurse educators, CNLs, and NPs play a very important role in the sustainability of innovations and new programs in practice (Bender, Williams, Su, & Hites, 2017; Grealish et al., 2015; Kaasalainen et al., 2015). The two CNLs in this study were instrumental in playing a facilitator role (thus influencing sustainability) and working with staff to change their practice towards person-centered care. The CNLs were in a dual role in the LTC homes. They were leaders in that they were in a position of authority, and they were facilitators as they shaped behaviours, built relationships, and fostered team-work using different approaches when working with staff to change their daily practice. Dogherty et al.

(2013) identified that credibility, flexibility, and the ability to use many different skills within the facilitator role are key in sustaining practice change (Waterman et al., 2015). Harvey and Lynch (2017) stated that it is important for facilitators to have the correct formula of "attributes, knowledge, and skills" that meet the unique needs of the organization (p. 2). In the medium sustainability home, the leadership was less involved in the day to day business of the LTC home. As a result, their influence over practice change in the LTC home was limited. Although the CNL in this home possessed the facilitation characteristics needed in this context, she was not able to do as much with staff because she did not have the same level of support from her manager as the CNL in the high sustainability home had. For facilitators to establish change, there must be support for their role and support for the program from leadership (Cranley et al., 2018; Dogherty et al., 2013; Harvey & Lynch, 2017; Rokstad et al., 2015; Waterman et al., 2015). The facilitation provided by the CNL supported the sustainability of the GPA program; however, their facilitation was not enough to sustain the GPA program. Effective formal leaders are required and appear to have a stronger role than facilitation in the sustainability of the program.

The GPA program is a complex psychosocial intervention that was created to help staff members in LTC homes provide care that is safe and respectful for the residents diagnosed with dementia and the staff members who provide care. This study found that sustainability of the GPA program was more likely to occur in LTC homes when all of the following were present: (a) informal facilitators are identified and used to champion the program, (b) GPA Coaches are not only expected to do facilitation but are trained to do it, (c) individuals in formal positions such as a CNL, are combined with strong leaders with appropriate facilitation skills, behaviours, and attributes (needed in the LTC setting). It has been posited that facilitation is not a singular role but one that is played by many (Harvey & Kitson, 2015a; Harvey & Lynch, 2017). The current research strongly supports this finding, given that the GPA program achieved and maintained sustainability at 15 months in LTC homes where facilitation was provided by CNLs, GPA Coaches, informal facilitators, and leaders with appropriate facilitation characteristics.

5.3.2 Relationship Between Facilitation, Leadership, and Sustainability of the GPA Program

Facilitation and leadership are two concepts within the i-PARIHS framework that have been studied independently of each other in the literature. This research brings them both together, and the findings provide us with a naturalistic view on facilitation, leadership, and the sustainability of a dementia-specific training program in rural LTC homes. The overall finding of

this research was that formal leadership within the seven LTC homes created the culture (ranging from institutional to person-centered) in which facilitators were either able or unable to influence the sustainability of the GPA program. In the homes where the leadership used punishment and fear, the culture of care was institutional and informal facilitators and GPA Coaches were unable to influence the sustainability of the GPA program. In homes where the leadership was strong and positive relationships were built with staff, the culture of care was person-centered and the informal facilitators and the GPA Coaches were able to influence and support sustainability of the GPA program. Additionally, the presence of a CNL with the facilitation skills, behaviours, and attributes needed in this setting contributed to the sustainability of the GPA program. The following discussion is an overview how these factors fit together in the realm of rural LTC homes.

5.3.3 The Larger Context of Rural LTC Homes

The context of an organization is recognized as a key consideration when implementing programs and innovations in health care settings. Previous researchers (Cummings, Estabrooks, Midodzi, Wallin, & Hayduk, 2007; Dopson, 2007; Estabrooks et al., 2015; McCormack et al., 2002; Stetler, Ritchie, Rycroft-Malone, Schultz, & Charns, 2007; van Beek & Gerritsen, 2010) as well as models and frameworks such as the Dynamic Sustainability Framework (DSF; Chambers, Glasgow, & Stange, 2013), Stages of Implementation (Fixsen et al., 2005), and the Practical, Robust Implementation for Sustainability Model (PRISM; Feldstein & Russell Glasgow, 2008) all mention the importance of context in sustaining new information. The original PARIHS framework identified context as a construct that was related to the successful implementation of evidence into practice. Sub-elements of context included culture, leadership, and evaluation. According to McCormack et al. (2002) in their conceptual analysis of the construct of context, "an understanding of context as the specific environment in which implementation, utilization, and creation of evidence may take place makes it easier to understand culture as a characteristic of context and one that shapes the dynamic and changing nature of practice" (p. 101). Context remains as a construct within the i-PARIHS framework but is further divided into the inner and outer context. Although leadership, culture, and evaluation are no longer identified as specific sub-elements in the i-PARIHS framework, Harvey and Kitson (2015a) identify that formal and informal leadership support as well as culture (at the local and organizational levels in the inner context), in addition to other factors (e.g., previous history with the innovation, evaluation and

feedback, and learning networks) are characteristics that must be considered by the facilitator during the overall implementation process.

Research has highlighted that contexts which are flexible, open to new ideas, and provide care based on resident wishes have more success in implementing and sustaining programs and innovations than those which are not (Nakrem, 2015). Nieboer and Strating (2012) reported that organizations that display characteristics of being innovative improve their culture of care even more by being less formal, by sharing information across professional groups and organizations, and by being willing to experiment with new ideas and programs. Given the importance of context, it is, therefore, pertinent to paint a picture of the larger overall context including the combined impact of leadership, culture of care, and facilitation on the sustainability of the GPA program in low, medium, and high sustainability homes. This discussion pulls together the findings from the papers on facilitation and leadership to highlight the complex nature of sustainability of interventions in rural LTC homes.

In the *low sustainability homes*, there were a number of strong negative influences that worked in combination against the sustainability of the GPA program. These included leadership characteristics, non-support of the GPA program, an institutional model of care, and the impact of the negative opinion leaders. The characteristics of the formal leaders were autocratic in nature, leading to an institutional culture of care. Autocratic leaders have been described as having control over others, using coercion to get results, and making decisions without the input of the staff members (Korniewicz, 2015). The formal leaders did not prioritize the GPA program and staff were aware of the lack of support for the GPA training. Within this institutional culture, care was completed based on tasks and routines of the staff, and the numerous negative opinion leaders were left alone to flourish. The negative opinion leaders had a large span of influence and they isolated and ridiculed the staff for practicing GPA. The impact of the leadership characteristics, culture of care, and negative opinion leaders could not be modified by the GPA Coaches and the informal facilitators in the low sustainability homes. Although there was some facilitation that was completed by the GPA Coaches and the informal facilitators, it was not strong enough on its own to overcome the leadership characteristics, the institutional culture of care, and the negative opinion leaders. See Figure 5.1 for further details.

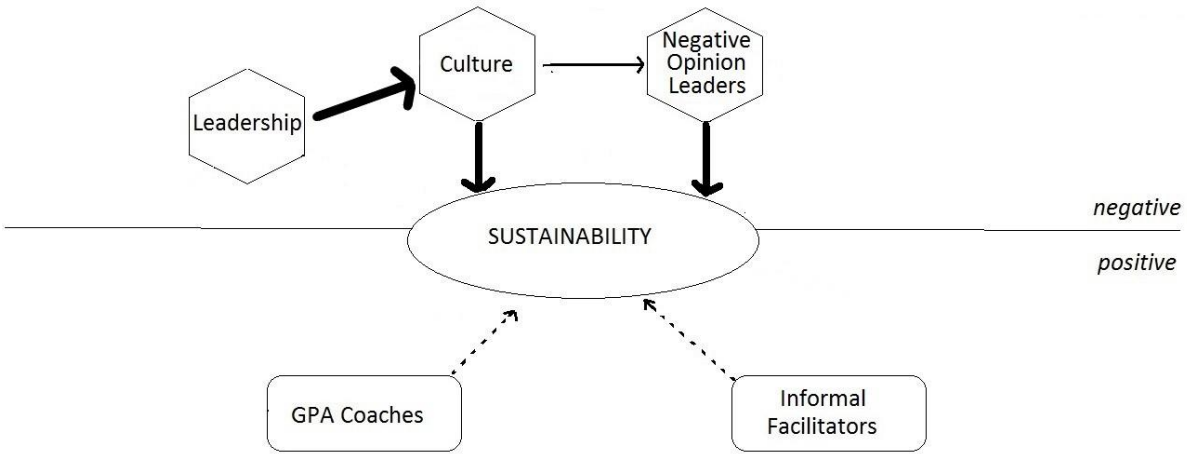

Figure 5.1. Positive and Negative Influences on the Sustainability of the GPA Program in Low Sustainability Homes.

In the *medium sustainability homes*, there were more positive influences (albeit weak) on the sustainability of the GPA program than negative influences. Positive influences included the characteristics of the formal leaders, the presence of a CNL, a less institutional culture of care (as compared to the low sustainability homes), and the presence of informal facilitators and GPA Coaches with facilitation skills, behaviours, and attributes. The characteristics of the formal leaders were not based on fear and punishment, but on distance and avoidance; similar to that of laissez-faire leaders (Korniewicz, 2015). The leaders verbally supported the GPA program, but their actions did not match their communications. Because of this, the culture was still institutional but there were more staff members practicing the GPA skills as compared to the low sustainability homes.

The CNL in the medium sustainability home in the retrospective study had similar facilitation skills, behaviours, and attributes as the CNL in the high sustainability home in the prospective study, however, the facilitation skills, behaviours, and attributes were not as effective as the CNL in the high sustainability home due to ineffective leadership characteristics and the institutional culture of care. There were more informal facilitators in the medium sustainability homes, and the GPA Coaches were able to influence sustainability to a minimal extent by role-modelling and coaching, but both groups alone were not able to sustain the GPA program. As in the low sustainability homes, the negative opinion leaders had a large span of influence over their co-workers and ultimately impacted the sustainability of the GPA program. Unfortunately, the leaders in the home did not address the negative opinion leaders unless they absolutely had to

(e.g., when a complaint to the union was made). Although there were more positive influences on sustainability in the medium sustainability homes, these influences were weaker as compared to the high sustainability homes. The laissez-faire leadership style, the mostly institutional culture of care, only verbal support for the GPA program from the leaders, and the strong influence of the negative opinion leaders impacted sustainability of the GPA program in the medium sustainability homes. See Figure 5.2 for a detailed depiction of the factors influencing sustainability in the medium sustainability homes.

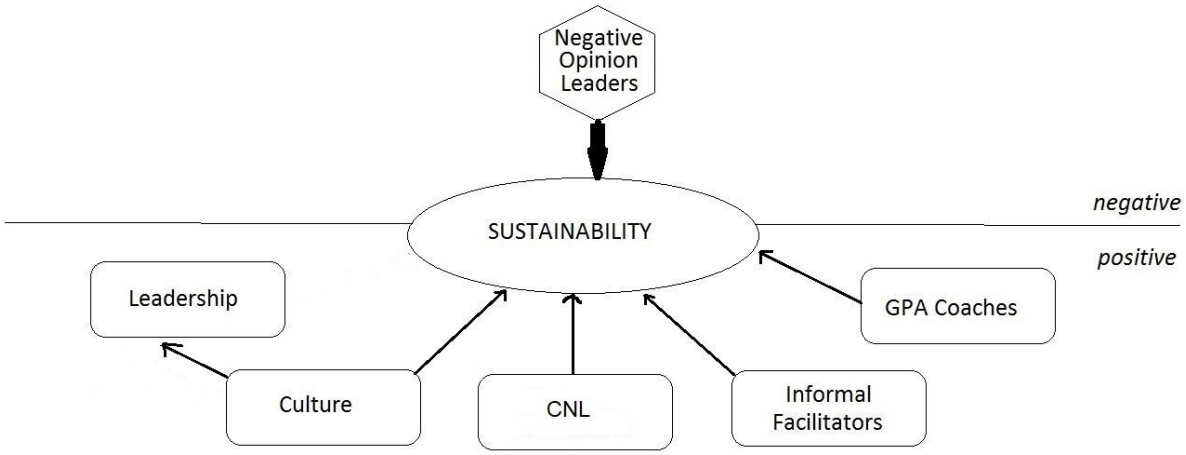

Figure 5.2. Positive and Negative Influences on the Sustainability of the GPA Program in Medium Sustainability Homes.

Within the *high sustainability homes*, there were more positive influences than negative influences that had an impact on the sustainability of the GPA program as compared to low and medium sustainability homes. These positive influences consisted of the formal leadership characteristics (with appropriate facilitation skills and behaviours), a person-centered culture of care, a CNL (who was also the GPA Coach) with appropriate facilitation skills and attributes, and strong facilitation by the GPA Coaches and informal facilitators. Formal leadership characteristics (with strong facilitation skills), a person-centered culture of care, and a CNL with appropriate skills, behaviours, and attributes who acted as the GPA Coach, had a stronger influence than the informal facilitators and GPA Coaches who were not CNLs. The term "appropriate" is from the definition of high facilitation in the PARIHS framework, where the fit of the facilitation roles and strategies meet the need of the situation and context (Rycroft-Malone, 2004).

In the high sustainability homes, the leaders displayed characteristics that were relationship-based, and the skills they used were interactive and social. These individuals made

the conscious choice to spend time in the nursing home every day so that they were connected to staff and the residents. This also contributed to the culture of care within the home. The culture of care that they created was person-centered, thus establishing an environment where the CNL, the GPA Coaches, and the informal facilitators were able to work with staff members in changing their practice. Within in this culture of care, the GPA program was an expectation for all staff, and the actions of the leaders visibly supported this. There were fewer negative opinion leaders in the high sustainability homes. These individuals had a smaller span of influence and their actions consisted of minimizing the impact of the GPA program instead of ridiculing or isolating the staff who practiced the GPA program. The leaders in the high sustainability homes addressed the behaviours of the negative opinion leaders, thus limiting their impact on the quality of life of the residents and staff in the LTC homes. See Figure 5.3 for further information on positive and negative influences on the sustainability of the GPA program in the high sustainability homes.

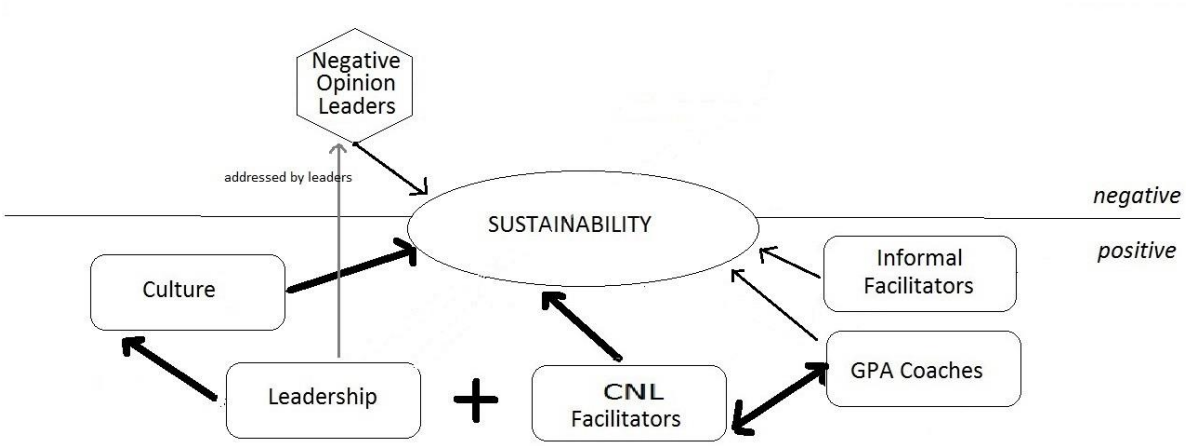

Figure 5.3. Positive and Negative Influences on the Sustainability of the GPA Program in High Sustainability Homes.

As evidenced by the three differing contexts in the low, medium, and high sustainability homes, there is a direct link between leadership characteristics, culture of care, and facilitation in the sustainability of the GPA program. Where there were strong leadership characteristics (including strong facilitation skills by the formal leader), a person-centered culture of care and formal facilitators who were able to work with staff to change their practice, short-term sustainability of the GPA program was achieved. Sustainability was not achieved in the medium sustainability home with the CNL who displayed similar facilitation characteristics to the CNL in the high sustainability home due to the laissez-faire leadership in the home. It is important to

highlight the role of the CNL in the medium and high sustainability homes in this study as other researchers have noted the impact of similar positions (e.g., NPs, nurse educators) and their influence on sustainability of evidence in previous research (Grealish et al., 2015; Kaasalainen et al., 2015).

It was difficult to find studies within the nursing literature that highlighted the importance of leadership, culture of care, and facilitation in the same study as they related to the sustainability of innovations and programs. Brown and McCormack (2016) looked at the role of facilitation and the development of psychological safety of staff in an acute care unit. In work environments where staff were not sufficiently supported, experienced oppressive behaviours, and had weak leadership, a holistic facilitator could help these individuals create a "safe space" so they would be able to examine their practice to improve patient care. Brown and McCormack argued that the idea of psychologically safe spaces is a missing factor within the i-PARIHS framework. Van der Zijpp et al. (2016) found that although a managerial leader or a facilitator alone had the potential to change practice, it was the relationship between the two that created sustainability. They also suggested that personal attributes and behaviours of the internal facilitators could make up for lack of support or negative leadership styles of the manager. This finding was not supported in the current study as the CNL in the medium sustainability home could not influence sustainability of the GPA program (as compared to the CNL in the high sustainability home) due to the laissez-faire leadership style of the formal leader in the retrospective study home.

Ritchie et al. (2017) argued that without leadership or facilitation, sustainability of innovations or programs is rare. If either leadership of facilitation is the lone intervention strategy, the chance of implementation is a challenge, but possible. However, when leadership and facilitation are present together, sustainability is highly achievable (Ritchie et al., 2017). Mekki et al. (2017) suggested that although context, evidence, and facilitation are important factors in successful implementation, it was leadership that had the greatest impact on sustainability. They found that it was the leaders who displayed stronger facilitation skills that motivated staff the most to use new evidence in their daily clinical practice. The current study not only supports the work mentioned above but it also brings together the importance of strong formal leadership, culture of care, and informal and formal facilitation. This study strengthens Harvey and Kitson's (2015a) idea that facilitation is not a singular role, but one that many individuals in the organization play (either as a part of a formal role or informally).

To support complex psychosocial initiatives like the GPA program, the current study findings suggests the following are required: (a) informal facilitators to champion the program, (b) GPA Coaches as formal facilitators, (c) a formal facilitator in a role of authority and with credibility (i.e., a CNL) amongst the staff and (d) strong leadership with appropriate facilitation skills who create a positive culture for implementation. These findings point to modifications of the i-PARIHS framework that may make it more applicable in LTC settings where staff have more interactions with their leadership than staff members who work in acute care settings. Leadership should be considered as the main construct, in conjunction with formal facilitation, as activators of the implementation process. The culture of care should also be given key consideration within the i-PARIHS framework when used to guide implementation of new programs, given that leaders play a key role in creating the environment in which staff work and residents live.

5.3.4 Rurality in LTC Homes

It is important to recognize the impact that rural settings may have on the sustainability of innovations and programs. A major finding across low and medium sustainability homes was that many staff members had a fear of offending a co-worker who may happen to live in the same small town as they do. Comments such as "I have to live next door to her, so I would never tell her how to handle a resident with responsive behaviours" were heard frequently. Staff members in the low and medium sustainability homes did not want to be ostracized at work or in their town by the negative opinion leaders or other staff members by making it sound as if they were "better than others."

Communities in rural areas tend to be close knit and therefore, the role of the nurse or NA bleeds into other areas within the community. It is not easy for staff in rural LTC homes to walk away from their job and not have to be faced with issues related to it in the community (e.g., a co-worker's child will not be allowed to play with another co-worker's child because they do not like each other at work). If there are issues between staff members, it is not as easy as quitting and moving to another job in a different LTC home. Relocating to another rural setting creates an entirely new set of problems (e.g., commuting distances, being away from family members). Staff members often choose to stay in the home and ignore the behaviour so as not to create waves in the community. This may be less of an issue in urban LTC homes because of the size of the

community, the opportunity to move to other LTC homes, and a less constricted social network of people in larger centres.

A second issue that occurred within the LTC homes was the duality of role of the CNL. As part of the western Canadian health care system, many rural LTC homes are often attached to an acute care site (or health care centre). The CNL or educator positions are sometimes split between the acute care site and the LTC home. In many instances in this study, the CNL spent more time in the acute care site because they were short nurses, or the emergency nurses needed extra assistance. The CNL was not able to work to the full scope of practice as an educator within the LTC home because this individual spent more time in the hospital as compared to the LTC home.

5.4 Recommendations for Future Practice

It is important to keep in mind the unique culture of LTC homes, particularly those in rural areas. Each home has different staffing levels, training requirements, resident acuity, and in-home resources (e.g., physiotherapy, behavioural supports, and clinical educators). The context of LTC homes are not the same as acute care sites which tend to have higher staffing levels and more access to resources and training opportunities. Due to the limitations that staff in LTC homes face, it is important not to paint these homes with the same brush as acute care homes when implementing new programs and ideas. The following recommendations are being made to help LTC homes implement and sustain complex psychosocial interventions that are similar to the GPA program.

1. In many acute care settings, there are specific educator positions that help staff implement new programs and ideas. Most LTC homes do not have a specific educator role, particularly those in rural areas. If senior leadership is looking to sustain best practice guidelines, it would be prudent to set aside funding for these positions in LTC homes. As mentioned previously, a CNL in the role of facilitator with the appropriate skills and attributes was shown to be a factor in the sustainability of interventions.
2. Ideally the LTC home and the acute care setting should each have their own educators. Not as much support can be given to the LTC home staff if the educator is spending most of their work week within the acute care setting.
3. A readiness for change assessment should be conducted in the LTC home before any new initiative is introduced to staff. It would be a financial and human resource waste if the

staff are not ready to change their practice or do not understand why they need to. An implementation framework such as i-PARIHS is helpful in guiding this process. Why implement new programs and innovations if the proper tools and keys to success are not in place? This is why frameworks have been created – to help identify barriers and facilitators to successful implementation prior to implementation.

4. When senior leadership are hiring individuals to be administrators, managers, or DOCs, it is important that they hire people with strong leadership skills, behaviours, and attributes. The rural community is small and boundaries are blended between home life and work life. In rural areas, it is important to hire individuals who are respected and have credibility not only in the health care system but in the community. It is also valuable for senior leadership to provide administrators, DOCs, and managers with leadership and facilitator training as there is a relationship between leadership skills, quality of care, and sustainability of interventions.
5. Formal leaders would benefit from mentoring and coaching by experienced leaders and facilitators to support practice change and decrease the turnover of administrators, DOCs, and managers in the LTC home.
6. Bullying and negative opinion leaders have a strong impact on the sustainability of programs and innovations. It is important to provide formal leaders in LTC homes with education on bullying and strategies on how to manage this problem. Prevention of bullying will decrease workplace stress and lead to better outcomes for staff and residents in LTC.
7. For innovations similar to the GPA program, facilitation should be a central component of the program after the initial training is completed. GPA Coaches should play a formal facilitation role beyond the 7.5 hour training, have protected time to facilitate, and be financially compensated for this role.
8. When new training programs are being implemented in LTC homes, the skills of the informal facilitators must be used to champion the program. These individuals should be identified prior to implementation, so that they are a part of the process to sustain practice change. Future research should focus on refining the literature related to the terms, skills, and behaviours of change agent positions.

5.5 Limitations

Although this study used several data collection methods and was conducted in seven LTC homes over a prolonged period of time, there are limitations that must be addressed. The results may be transferable to similar settings, but the generalizability of the findings to urban LTC homes is not known. Although seven rural LTC homes were selected for this research study, urban LTC homes were not included. As a result, other contextual issues (e.g., financial constraints of having larger numbers of staff in larger nursing homes who need to be trained or in larger LTC homes with a larger number of casual staff who may not receive the GPA training) within the urban homes may be present that potentially could shed light on the relationship between facilitation, leadership, and sustainability of the GPA program that were not identified in the current findings. Although this research focused on rural LTC homes, the findings may be applicable to all LTC homes, and provide a foundation for other researchers (in different areas of Canada, and world-wide) to further explore the impact of facilitation and leadership on sustainability of innovations in LTC. These results are breaking new ground not only in the refinement of the i-PARIHS framework, but also in combining two often separated research foci – leadership and facilitation.

Within the retrospective study, data were collected at only one point in time due to the number of LTC homes and the distances required to travel to them. Interviews and focus groups were held during the week (i.e., M – F) and between the hours of 8:00 am and 5:00 pm. Focus groups may also have led to the inhibition of NAs telling their story in front of their co-workers (particularly if they were in the focus group with a negative opinion leader). Semi-structured one-on-one interviews may be a safer avenue to gain the perspective of NAs on the sustainability of the GPA program. Additionally, more than one focus group could be held at different times of the day/week to enable more NAs (who may work only evenings and weekends) to attend. Semi-structured interviews could have been conducted more than once to include a variety of staff members from each of the homes across the evening and night shifts. In the retrospective study, only formal leaders, nurses, GPA Coaches, and NAs were interviewed and included in the focus groups due to the time constraints of data collection. As in the prospective study, all staff members who work in the LTC homes should be included in future research studies that examine the factors related to the sustainability of the GPA program. In addition, family members and residents within the LTC home were not included in this research and should be included in future

studies to gain their unique perspectives of leadership, facilitation and sustainability of the GPA program. Observations within the prospective study were conducted during the week (Monday – Friday) between the hours of 8:00 am – 5:00 pm. The researcher only observed in the public areas of the LTC home (e.g.., dining room, recreational space, etc.) and therefore was only able to infer what happened behind closed doors, based on what the staff charted or relayed during the brief discussions that were completed with the staff.

5.6 Future Research

This research focused on formal caregivers in rural LTC homes and their perspectives on factors that influences sustainability of the GPA program (i.e., facilitation, leadership, and culture of care). Future research could focus on the family members and what they identify as factors contributing to success or failure of innovations like the GPA program in LTC homes. This research did not measure the culture of care prior to the implementation of the GPA program in the LTC homes. Future researchers could conduct an assessment using a quantitative tool to measure the culture of care prior to and after the implementation of a complex intervention similar to the GPA program to help shed light on the factors that influence the implementation process. The impact of formalized leadership and facilitation training (in additional to ongoing mentorship) for administrators, DOCs, and managers in rural LTC homes is important. Future prospective, longitudinal studies similar to this research could highlight how these types of training programs influence the culture of care, employee engagement, and the sustainability of complex psychosocial interventions in rural LTC homes over time is recommended. Finally, in the future, it would be important to highlight the NA outcomes in relation to the GPA program. Specifically, it is important to know if dementia-specific training programs impact stress levels, burnout, and sick leave for NAs in LTC homes.

5.7 Conclusion

This research focused on the overall relationship between facilitation, leadership, and culture of care in rural LTC homes, and the role that these played in the sustainability of the GPA program. It has been identified that leadership characteristics create a culture of care in which individuals completing facilitation are able (or not able) to create practice change. The stronger the leadership characteristics, the more person-centered the culture of care is, which leads to an organization that enables facilitators to help staff create change. In support of previous research, leaders who create person-centered cultures of care display interactive, social, and relationship building skills that

enable staff to use the GPA program in their daily practice. The i-PARIHS framework highlights that facilitation is the mechanism by which practice change is achieved. It is strongly recommended that i-PARIHS framework be refined to integrate the strong role that leadership plays in LTC homes related to the sustainability of best practice. Leadership (a stronger factor in sustainability) and facilitation should be considered together as the active ingredients in the sustainability of new programs and innovations in LTC homes.

References

Advanced Gerontological Education. (2015). *Gentle persuasive approaches (GPA) in dementia care: Supporting persons with responsive behaviours* (3rd ed.).

Advanced Gerontological Education. (2017a). Gentle persuasive approaches (GPA) coach certification agreement. Retrieved from https://www2.ageinc.ca/documents/Coach_Agreement_2017.pdf

Advanced Gerontological Education. (2017b). Gentle persuasive approaches fact sheet. Retrieved from https://ageinc.s3.amazonaws.com/uploads/2017/01/ENG_2017_GPA_FACT-SHEET_3RD-EDITION.pdf

Advanced Gerontological Education. (2017c). GPA eLearning. Retrieved from https://www.gpaelearn.com/learning

Advanced Gerontological Education. (2017d). GPA recharge. Retrieved from https://ageinc.ca/gpaadp/gpa-recharged/

Advanced Gerontological Education. (2017e). GPA renewal schedule. Retrieved from https://ageinc.ca/gpaadp/renewal-schedule-2/

Allen, J., Linnan, L., & Emmons, K. M. (2012). Fidelity and its relationship to implementation effectiveness, adaptation, and dissemination. In R. C. Brownson, G. A. Colditz, & E. K. Proctor (Eds.), *Dissemination and implementation research in health: Translating science to practice* (pp. 281–304). New York, NY: Oxford University Press.

Alzheimer Society of Canada. (2010). Rising tide: The impact of dementia on Canadian society. Retrieved from http://alzheimer.ca/sites/default/files/Files/national/Advocacy/ASC_Rising_Tide_Full_Report_e.pdf

Alzheimer Society of Canada. (2016). *Prevalence and monetary costs of dementia in Canada (2016): A report by the Alzheimer Society of Canada*. Retrieved from www.alzheimer.ca/~/media/Files/national

Alzheimer Society of Canada. (2017a). Understanding behaviour. Retrieved from http://alzheimer.ca/en/Home/Living-with-dementia/Understanding-behaviour

Alzheimer Society of Canada. (2017b). What is dementia? Retrieved from http://www.alzheimer.ca/en/About-dementia/What-is-dementia

Alzheimer Society of Canada. (2018a). Dementia numbers in Canada. Retrieved from http://alzheimer.ca/en/Home/About-dementia/What-is-dementia/Dementia-numbers

Alzheimer Society of Canada. (2018b). Latest information and statistics. Retrieved from http://alzheimer.ca/en/Home/Get-involved/Advocacy/Latest-info-stats

Aylward, S., Stolee, P., Keat, N., & Johncox, V. (2003). Effectiveness of continuing education in long-term care: A literature review. *The Gerontologist*, *43*(2), 259–271. Retrieved from https://academic.oup.com/gerontologist

Backman, A., Sjögren, K., Lindkvist, M., Lövheim, H., & Edvardsson, D. (2016). Towards person-centeredness in aged care - exploring the impact of leadership. *Journal of Nursing Management*, *24*(6), 766–774. https://doi.org/10.1111/jonm.12380

Backman, A., Sjögren, K., Lindkvist, M., Lövheim, H., & Edvardsson, D. (2017). Characteristics of highly rated leadership in nursing homes using item response theory. *Journal of Advanced Nursing*, *73*(12), 2903–2913. https://doi.org/10.1111/jan.13353

Bacsu, J. R., Jeffery, B., Johnson, S., Martz, D., Novik, N., & Abonyi, S. (2012). Health aging in place: Supporting rural seniors' health needs. *Online Journal of Rural Nursing and Health Care*, *12*(2), 77–87. Retrieved from https://rnojournal.binghamton.edu/index.php/RNO

Baernholdt, M., Yan, G., Hinton, I., Rose, K., & Mattos, M. (2012). Quality of life in rural and urban adults 65 years and older: Findings from the national health and nutrition examination survey. *The Journal of Rural Health*, *28*(4), 339–347. https://doi.org/10.1111/j.1748-0361.2011.00403.x

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs: NJ: Prentice Hall.

Banerjee, A., Daly, T., Armstrong, H., Armstrong, P., Lafrance, S., & Szebehely, M. (2008). *"Out of control": Violence against personal support workers in long-term care*. Retrieved from https://www.longwoods.com/articles/images/Violence_LTC_022408_Final.pdf

Bass, D., & Judge, K. (2010). Challenges implementing evidence-based programs. *Generations*, *34*(1), 51–58. Retrieved from https://www.asaging.org/generations-journal-american-society-aging

Bauer, M. S., Damschroder, L., Hagedorn, H., Smith, J., & Kilbourne, A. M. (2015). An introduction to implementation science for the non-specialist. *BMC Psychology*, *3*(1), 32. https://doi.org/10.1186/s40359-015-0089-9

Bender, M., Williams, M., Su, W., & Hites, L. (2017). Refining and validating a conceptual model of clinical nurse leader integrated care delivery. *Journal of Advanced Nursing*, *73*(2), 448–464. https://doi.org/10.1111/jan.13113

Berkel, C., Mauricio, A. M., Schoenfelder, E., & Sandler, I. N. (2011). Putting the pieces together: An integrated model of program implementation. *Prevention Science*, *12*(1), 23–33. https://doi.org/10.1007/s11121-010-0186-1

Bethell, J., Chu, C. H., Wodchis, W. P., Walker, K., Stewart, S. C., & McGilton, K. S. (2018). Supportive supervision and staff intent to turn over in long-term care homes. *The Gerontologist*, *58*(5), 953–959. https://doi.org/10.1093/geront/gnx008

Bhattacharyya, O., Reeves, S., & Zwarenstein, M. (2009). What is implementation research?: Rationale, concepts, and practices. *Research on Social Work Practice*, *19*(5), 491–502. https://doi.org/10.1177/1049731509335528

Birks, M., & Mills, J. (2015). *Grounded theory : a practical guide*. London, UK: SAGE.

Boersma, P., van Weert, J. C. M., Lakerveld, J., & Dröes, R.-M. (2015). The art of successful implementation of psychosocial interventions in residential dementia care: a systematic review of the literature based on the RE-AIM framework. *International Psychogeriatrics*, *27*(01), 19–35. https://doi.org/10.1017/S1041610214001409

Boscart, V. (2016). *Dementia in Canada*. Retrieved from https://rnao.ca/sites/rnao-ca/files/Confidential_Joint_Submission_re_Dementia_-_May_24_2016.pdf

Boström, A.-M., Kajermo, K. N., Nordström, G., & Wallin, L. (2009). Registered nurses' use of research findings in the care of older people. *Journal of Clinical Nursing*, *18*(10), 1430–1441. https://doi.org/10.1111/j.1365-2702.2008.02370.x

Boström, A.-M., Squires, J. E., Mitchell, A., Sales, A. E., & Estabrooks, C. A. (2012). Workplace aggression experienced by frontline staff in dementia care. *Journal of Clinical Nursing*, *21*(9–10), 1453–1465. https://doi.org/10.1111/j.1365-2702.2011.03924.x

Bowman, C., & Meyer, J. (2017). Care home leadership: Action is needed. *Age and Ageing*, *46*(4), 534–535. https://doi.org/10.1093/ageing/afx030

Bradley, E. H., Webster, T. R., Baker, D., Schlesinger, M., Inouye, S. K., Barth, M. C., … Koren, M. J. (2004a). Translating research into practice: speeding the adoption of innovative health care programs. *Issue Brief (Commonwealth Fund)*, (724), 1–12. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15270051

Bradley, E. H., Webster, T. R., Baker, D., Schlesinger, M., Inouye, S. K., Barth, M. C., … Koren, M. J. (2004b). Translating research into practice: Speeding the adoption of innovative health care programs. Retrieved from www.cmwf.org

Brazil, K., Royle, J. A., Montemuro, M., Blythe, J., & Church, A. (2004). Moving to evidence-based practice in long-term care: The role of a best practise resource centre in two long-term care settings. *Journal of Gerontological Nursing*, *30*(3), 14–19. Retrieved from https://www.healio.com/nursing/journals/jgn

Brodaty, H., Draper, B., Saab, D., Low, L.-F., Richards, V., Paton, H., & Lie, D. (2001). Psychosis, depression and behavioural disturbances in Sydney nursing home residents: Prevalence and predictors. *International Journal of Geriatric Psychiatry*, *16*(5), 504–512. https://doi.org/10.1002/gps.382

Brooker, D., & Latham, I. (2016). *Person-centered dementia care : Making services better with the VIPS framework.* (Second Edi). Philadelphia, PA: Jessica Kingsley Publishers.

Brown, D., & McCormack, B. (2005). Developing postoperative pain management: Utilising the Promoting Action on Research Implementation in Health Services (PARIHS) framework. *Worldviews on Evidence-Based Nursing*, *2*(3), 131–141. https://doi.org/10.1111/j.1741-6787.2005.00024.x

Brown, D., & McCormack, B. (2016). Exploring psychological safety as a component of facilitation within the Promoting Action on Research Implementation in Health Services framework. *Journal of Clinical Nursing*, *25*(19–20), 2921–2932. https://doi.org/10.1111/jocn.13348

Brownie, S., & Nancarrow, S. (2013). Effects of person-centered care on residents and staff in aged-care facilities: A systematic review. *Clinical Interventions in Aging*, *8*, 1–10. https://doi.org/10.2147/CIA.S38589

Canadian Rural Revitalization Foundation. (2015). *State of rural Canada report*. Retrieved from http://sorc.crff.ca/wp.content/uploads/2015/09/SORC2015.pdf

Casey, M., O' Leary, D., & Coghlan, D. (2018). Unpacking action research and implementation science: Implications for nursing. *Journal of Advanced Nursing*, *74*(5), 1051–1058. https://doi.org/10.1111/jan.13494

Caspar, S., Cooke, H. A., Phinney, A., & Ratner, P. A. (2016). Practice change interventions in long-term care facilities: What works, and why? *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement*, *35*(03), 372–384. https://doi.org/10.1017/S0714980816000374

Cassidy, E. L., Rosen, C., Cook, J., Greenbaum, M. A., Chow, H., Solano, N., & Sheikh, J. I. (2005). Assessment to intervention. *Clinical Gerontologist*, *28*(4), 29–42. https://doi.org/10.1300/J018v28n04_03

Century, J., Rudnick, M., & Freeman, C. (2010). A framework for measuring fidelity of implementation: A foundation for shared language and accumulation of knowledge. *American Journal of Evaluation*, *31*(2), 199–218. https://doi.org/10.1177/1098214010366173

Cerejeira, J., Lagarto, L., Mukaetova-Ladinska, E. B., Massano, J., & Agosta, F. (2012). Behavioral and psychological symptoms of dementia. *Frontiers in Neurology*, *3*, Article 73. https://doi.org/10.3389/fneur.2012.00073

Chambers, D. A., Glasgow, R. E., & Stange, K. C. (2013). The dynamic sustainability framework: Addressing the paradox of sustainment amid ongoing change. *Implementation Science*, *8*(1), 117. https://doi.org/10.1186/1748-5908-8-117

Charmaz, K. (2006). *Constructing grounded theory: A practical guide throuh qualitative analysis*. Thousand Oaks, CA: Sage Publications, Inc.

Charmaz, K. (2008). Constructionism and the ground theory method. In J. A. Holstein & J. F. Gubrium (Eds.), *Handbook of Constructionist Research* (pp. 397–412). New York, NY: The Guilford Press.

Chipp, C., Dewane, S., Brems, C., Johnson, M. E., Warner, T. D., & Roberts, L. W. (2011). "If only someone had told me…": Lessons from rural providers. *The Journal of Rural Health*, *27*(1), 122–130. https://doi.org/10.1111/j.1748-0361.2010.00314.x

Chu, C. H., Wodchis, W. P., & McGilton, K. S. (2014). Turnover of regulated nurses in long-term care facilities. *Journal of Nursing Management*, *22*(5), 553–562. https://doi.org/10.1111/jonm.12031

Clarke, C., Wolverson, E., & Moniz-Cook, E. (2016). A positive psychology approach to dementia. In *Positive Psychology Approaches to Dementia* (pp. 41–66). Philadelphia, PA: Jessica Kingsley Publishers.

Colón-Emeric, C., Toles, M., Cary, M. P., Batchelor-Murphy, M., Yap, T., Song, Y., … Anderson, R. A. (2015). Sustaining complex interventions in long-term care: A qualitative study of direct care staff and managers. *Implementation Science*, *11*(1), 94. https://doi.org/10.1186/s13012-016-0454-y

Corazzini, K., Twersky, J., White, H. K., Buhr, G. T., McConnell, E. S., Weiner, M., & Colón-Emeric, C. S. (2015). Implementing culture change in nursing homes: An adaptive leadership framework. *The Gerontologist*, *55*(4), 616–627. https://doi.org/10.1093/geront/gnt170

Cranley, L. A., Cummings, G. G., Profetto-McGrath, J., Toth, F., & Estabrooks, C. A. (2017). Facilitation roles and characteristics associated with research use by healthcare professionals: A scoping review. *BMJ Open*, *7*(8). https://doi.org/10.1136/bmjopen-2016-014384

Cranley, L. A., Hoben, M., Yeung, J., Estabrooks, C. A., Norton, P. G., & Wagg, A. (2018). SCOPEOUT: Sustainability and spread of quality improvement activities in long-term care-a mixed methods approach. *BMC Health Services Research*, *18*(1), 174. https://doi.org/10.1186/s12913-018-2978-0

Crowe, M. (2005). Discourse analysis: Towards an understanding of its place in nursing. *Journal of Advanced Nursing*, *51*(1), 55–63. https://doi.org/10.1111/j.1365-2648.2005.03461.x

Cummings, G. G., Estabrooks, C. A., Midodzi, W. K., Wallin, L., & Hayduk, L. (2007). Influence of organizational characteristics and context on research utilization. *Nursing Research*, *56*(Supplement 1), S24–S39. https://doi.org/10.1097/01.NNR.0000280629.63654.95

Dal Bello-Haas, V. P. M., Cammer, A., Morgan, D., Stewart, N., & Kosteniuk, J. (2014). Rural and remote dementia care challenges and needs: Perspectives of formal and informal care providers residing in Saskatchewan, Canada. *Rural and Remote Health*, *14*(3), 2747. Retrieved from https://www.rrh.org.au/

Daly, T., Banerjee, A., Armstrong, P., Armstrong, H., & Szebehely, M. (2011). Lifting the 'violence veil': Examining working conditions in long-term care facilities using iterative mixed methods. *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement*, *30*(02), 271–284. https://doi.org/10.1017/S071498081100016X

Daniels, Z. M., VanLeit, B. J., Skipper, B. J., Sanders, M. L., & Rhyne, R. L. (2007). Factors in recruiting and retaining health professionals for rural practice. *The Journal of Rural Health*, *23*(1), 62–71. https://doi.org/10.1111/j.1748-0361.2006.00069.x

Danylyshen-Laycock, T. (2009). *Recommendation of a violence awareness program: Review of the literature* (unpublished).

Davies, B., Tremblay, D., & Edwards, N. (2010). Sustaining evidence-based practice systems and measuring the impacts. In D. Bick & I. Graham (Eds.), *Evaulating the impact of implementing evidence-based practice* (pp. 166–188). West Sussex, UK: Wiley-Blackwell.

Davis, D., Evans, M., Jadad, A., Perrier, L., Rath, D., Ryan, D., … Zwarenstein, M. (2003). The case for knowledge translation: Shortening the journey from evidence to effect. *BMJ (Clinical Research Ed.)*, *327*(7405), 33–35. https://doi.org/10.1136/bmj.327.7405.33

Davison, T. E., McCabe, M. P., Bird, M., Mellor, D., MacPherson, S., Hallford, D., … O'Connor, D. W. (2017). Behavioral symptoms of dementia that present management difficulties in nursing homes: Staff perceptions and their concordance with informant scales. *Journal of Gerontological Nursing*, *43*(1), 34–43. https://doi.org/10.3928/00989134-20160928-01

deValpine. (2014). *Extreme nursing: A qualitative assessment of nurse retention in a remote setting*. Deakin University. Retrieved from https://www.rrh.org.au/journal/article/2859

Dijkstra, R., Wensing, M., Thomas, R., Akkermans, R., Braspenning, J., Grimshaw, J., & Grol, R. (2006). The relationship between organisational characteristics and the effects of clinical guidelines on medical performance in hospitals, a meta-analysis. *BMC Health Services Research*, *6*, 53. https://doi.org/10.1186/1472-6963-6-53

Dogherty, E. J., Harrison, M. B., & Graham, I. D. (2010). Facilitation as a role and process in achieving evidence-based practice in nursing: A focused review of concept and meaning. *Worldviews on Evidence-Based Nursing*, *7*(2), 76–89. https://doi.org/10.1111/j.1741-6787.2010.00186.x

Dogherty, E. J., Harrison, M. B., Graham, I. D., Vandyk, A. D., & Keeping-Burke, L. (2013). Turning knowledge into action at the point-of-care: The collective experience of nurses facilitating the implementation of evidence-based practice. *Worldviews on Evidence-Based Nursing*, *10*(3), 129–139. https://doi.org/10.1111/wvn.12009

Dogherty, E. J., Harrison, M., Graham, I., & Keeping-Burke, L. (2014). Examining the use of facilitation within guideline dissemination and implementation studies in nursing. *International Journal of Evidence-Based Healthcare*, *12*(2), 105–127. https://doi.org/10.1097/XEB.0000000000000008

Dopson, S. (2007). A view from organizational studies. *Nursing Research*, *56*(4), s72–s77. Retrieved from https://journals.lww.com/nursingresearchonline/pages/default.aspx

Duffy, F. (2016). A social work perspective on how ageist language, discourses and understandings negatively frame older people and why taking a critical social work stance is essential. *British Journal of Social Work*, *47*(7), bcw163. https://doi.org/10.1093/bjsw/bcw163

Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology*, *41*(3–4), 327–350. https://doi.org/10.1007/s10464-008-9165-0

Eaton, S. C. (2003). Frontline caregivers in nursing facilities: Can policy help in recruitment and retention crisis? *Public Policy & Aging Report*, *13*(2), 8–11. https://doi.org/10.1093/ppar/13.2.8

Eccles, M. P., & Mittman, B. S. (2006). Welcome to implementation science. *Implementation Science*, *1*(1), 1. https://doi.org/10.1186/1748-5908-1-1

Edward, K., Ousey, K., Warelow, P., & Lui, S. (2014). Nursing and aggression in the the workplace : A systematic review. *British Journal of Nursing*, *23*(12), 653–659.

Eliopoulos, C. (2013). Affecting culture change and performance improvement in Medicaid nursing homes: The promote understanding, leadership, and learning (PULL) program. *Geriatric Nursing*, *34*(3), 218–223. https://doi.org/10.1016/j.gerinurse.2013.02.015

Emerson, R., Fretz, R., & Shaw, L. (1995). *Writing ethnographic fieldnotes*. Chicago: University of Chicago Press.

Engle, R. L., Tyler, D. A., Gormley, K. E., Afable, M. K., Curyto, K., Adjognon, O. L., … Sullivan, J. L. (2017). Identifying barriers to culture change: A qualitative analysis of the obstacles to delivering resident-centered care. *Psychological Services*, *14*(3), 316–326. https://doi.org/10.1037/ser0000169

Estabrooks, C. A., Squires, J. E., Carleton, H. L., Cummings, G. G., & Norton, P. G. (2015). Who is looking after mom and dad? Unregulated workers in Canadian long-term care homes. *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement*, *34*(1), 47–59. https://doi.org/10.1017/S0714980814000506

Estabrooks, C. A., Squires, J. E., Hayduk, L., Morgan, D., Cummings, G. G., Ginsburg, L., … Norton, P. G. (2015). The influence of organizational context on best practice use by care aides in residential long-term care settings. https://doi.org/10.1016/j.jamda.2015.03.009

Evashwick, C., & Ory, M. (2003). Organizational characteristics of successful innovative health care programs sustained over time. *Family & Community Health*, *26*(3), 177–193. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/12829940

Fazio, S., Pace, D., Flinner, J., & Kallmyer, B. (2018). The fundamentals of person-centered care for individuals with dementia. *The Gerontologist*, *58*(suppl_1), S10–S19. https://doi.org/10.1093/geront/gnx122

Feldstein, A. C., & Russell Glasgow, M. E. (2008). A practical, robust implementation and sustainability model (PRISM) for integrating research findings into practice research methods. *The Joint Commission Journal on Quality and Patient Safety*, *34*(4), 228-243. https://doi.org/10.1016/S1553-7250(08)34030-6

Fernandes, C. M., Bouthillette, F., Raboud, J. M., Bullock, L., Moore, C. F., Christenson, J. M., … Way, M. (1999). Violence in the emergency department: A survey of health care workers. *CMAJ : Canadian Medical Association Journal*, *161*(10), 1245–1248. Retrieved from http://www.cmaj.ca/

Fitzgerald, C. E., & Townsend, R. P. (2012). Assessing the continuing education needs and preferences of rural nurses. *The Journal of Continuing Education in Nursing*, *43*(9), 420–427. https://doi.org/10.3928/00220124-20120615-76

Fitzgerald, L., & Dopson, S. (2009). Comparative case study designs: Their utility and development in organizational research. In D. A. Buchanan & A. Bryman (Eds.), *The SAGE handbook of organizational research methods.* (pp. 465–499). Thousand Oaks, CA: Sage Publications, Inc.

Fixsen, D. L., Naoom, S. F., Blasé, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL. Retrieved from https://nirn.fpg.unc.edu/sites/nirn.fpg.unc.edu/files/resources/NIRN-MonographFull-01-2005.pdf

Fleiszer, A. R., Semenic, S. E., Ritchie, J. A., Richer, M.C., & Denis, J.L. (2015a). An organizational perspective on the long-term sustainability of a nursing best practice guidelines program: A case study. *BMC Health Services Research*, *15*(1), 535. https://doi.org/10.1186/s12913-015-1192-6

Fleiszer, A. R., Semenic, S. E., Ritchie, J. A., Richer, M.-C., & Denis, J.L. (2015b). The sustainability of healthcare innovations: A concept analysis. *Journal of Advanced Nursing*, *71*(7), 1484–1498. https://doi.org/10.1111/jan.12633

Fleiszer, A. R., Semenic, S. E., Ritchie, J. A., Richer, M.C., & Denis, J.L. (2016). Nursing unit leaders' influence on the long-term sustainability of evidence-based practice improvements. *Journal of Nursing Management*, *24*(3), 309–318. https://doi.org/10.1111/jonm.12320

Flottorp, S. A., Oxman, A. D., Krause, J., Musila, N. R., Wensing, M., Godycki-Cwirko, M., … Eccles, M. P. (2013). A checklist for identifying determinants of practice: A systematic review and synthesis of frameworks and taxonomies of factors that prevent or enable improvements in healthcare professional practice. *Implementation Science*, *8*(1), 35. https://doi.org/10.1186/1748-5908-8-35

Forbes, D., & Hawranik, P. (2012). Looming dementia care crisis: Are canadian rural and remote settings ready? In J. Kulig & A. Williams (Eds.), *Health in rural Canada* (pp. 447–461). Vancouver: UBCPRess.

Fox, N. (2007). *The journey of a lifetime: Leadership pathways to culture change in long-term care.* United States: Action Pact, Inc.

Frampton, S., Gil, H., Guastello, S., Kinsey, J., Boudreau-Scott, D., Lepore, M., … Thomas, B. (2010). *Long-term care improvement guide*. Retrieved from www.planetree.orgwww.pickerinstitute.org

Gates, D., Fitzwater, E., & Deets, C. (2005). Development of instruments to assess assaultive behaviour in nursing homes. *Journal of Gerontological Nursing*, *29*(8), 37–45. Retrieved from http://www.jognonline.com/

Gates, D., Fitzwater, E., & Succop, P. (2003). Relationships of stressors, strain, and anger to caregiver assaults. *Issues in Mental Health Nursing*, *24*, 775–793. https://doi.org/10.1080/01612840390228040

Gates, D., Fitzwater, E., & Succop, P. (2005). Reducing assaults against nursing home caregivers. *Nursing Research*, *54*(2), 119–127. Retrieved from https://journals.lww.com/nursingresearchonline/pages/default.aspx

Gerberich, S. G., Church, T. R., McGovern, P. M., Hansen, H. E., Nachreiner, N. M., Geisser, M. S., … Watt, G. D. (2004). An epidemiological study of the magnitude and consequences of work related violence: The Minnesota Nurses' Study. *Occupational and Environmental Medicine*, *61*(6), 495–503. Retrieved from https://oem.bmj.com/

Gillies, L., Coker, E., Montemuro, M., & Pizzacalla, A. (2015). Sustainability of an innovation to support and respond to persons with behaviors related to dementia and delirium. *JONA: The Journal of Nursing Administration*, *45*(2), 70–73. https://doi.org/10.1097/NNA.0000000000000160

Gilmour, J. A., & Brannelly, T. (2010). Representations of people with dementia - subaltern, person, citizen. *Nursing Inquiry*, *17*(3), 240–247. https://doi.org/10.1111/j.1440-1800.2009.00475.x

Gochros, H. (2005). Interviewing. In R. Grinnell & Y. Unrau (Eds.), *Social work research and evaluation: Quantitative and qualitative approaches* (7th ed., pp. 245–269). New York, NY: Oxford University Press.

Goodridge, D. M., Johnston, P., & Thomson, M. (1996). Conflict and aggression as stressors in the work environment of nursing assistants. *Journal of Elder Abuse & Neglect*, *8*(1), 49–67. https://doi.org/10.1300/J084v08n01_03

Government of Saskatchewan (1996). *The occupational health and safety regulations 1996*. Retrieved from http://www.qp.gov.sk.ca/documents/english/regulations/regulations/o1-1r1.pdf

Graham, I. D., Logan, J., Harrison, M. B., Straus, S. E., Tetroe, J., Caswell, W., & Robinson, N. (2006). Lost in knowledge translation: Time for a map? *Journal of Continuing Education in the Health Professions*, *26*(1), 13–24. https://doi.org/10.1002/chp.47

Grand, J. H., Caspar, S., & Macdonald, S. W. (2011). Clinical features and multidisciplinary approaches to dementia care. *Journal of Multidisciplinary Healthcare*, *4*, 125–147. https://doi.org/10.2147/JMDH.S17773

Graydon, J., Kasta, W., & Khan, P. (1994). Verbal and physical abuse of nurses. *Canadian Journal of Nursing Administration*, *7*(4), 70–89. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/7888411

Grealish, L., Henderson, A., Quero, F., Phillips, R., & Surawski, M. (2015). The significance of 'facilitator as a change agent' - organisational learning culture in aged care home settings. *Journal of Clinical Nursing*, *24*(7–8), 961–969. https://doi.org/10.1111/jocn.12656

Greenhalgh, T., Howick, J., Maskrey, N., Brassey, J., Burch, D., Burton, M., … Spence, D. (2014). Evidence based medicine: A movement in crisis? *BMJ (Online)*, *348*. https://doi.org/10.1136/bmj.g3725

Haggarty, J. M., Ryan-Nicholls, K., & Jarva, J. (2010). Mental health collaborative care: A synopsis of the rural and isolated toolkit. *Rural and Remote Health*, *10*(3). Retrieved from https://www.rrh.org.au

Handley, M., Bunn, F., & Goodman, C. (2017). Dementia-friendly interventions to improve the care of people living with dementia admitted to hospitals: A realist review. *BMJ Open*, *7*. https://doi.org/10.1136/bmjopen-2016-015257

Harnett, T., & Jönson, H. (2017). “They are different now” - Biographical continuity and disruption in nursing home settings. *Journal of Aging Studies*, *42*, 1–8. https://doi.org/10.1016/j.jaging.2017.05.003

Harvey, G., & Kitson, A. (2015a). A model of facilitation for evidence-based practice. In G. Harvey & A. Kitson (Eds.), *Implementing evidence-based practice in healthcare: A facilitation guide* (pp. 47–69). New York, NY: Routledge.

Harvey, G., & Kitson, A. (2015b). PARIHS re-visited: Introducing the i-PARIHS framework. In G. Harvey & A. Kitson (Eds.), *Implementing evidence-based practice in healthcare: A facilitation guide* (pp. 25–46). New York, NY: Routledge.

Harvey, G., & Kitson, A. (2016). PARIHS revisited: From heuristic to integrated framework for the successful implementation of knowledge into practice. *Implementation Science*, *11*, 33–45. https://doi.org/10.1186/s13012-016-0398-2

Harvey, G., Loftus-Hills, A., Rycroft-Malone, J., Titchen, A., Kitson, A., McCormack, B., & Seers, K. (2002). Getting evidence into practice: The role and function of facilitation. *Journal of Advanced Nursing*, *37*(6), 577–588. Retrieved from https://onlinelibrary.wiley.com/journal/13652648

Harvey, G., & Lynch, E. (2017). Enabling continuous quality improvement in practice: The role and contribution of facilitation. *Frontiers in Public Health*, *5*, 1–5. https://doi.org/10.3389/fpubh.2017.00027

Helfrich, C. D., Damschroder, L. J., Hagedorn, H. ., Daggett, G. S., Sahay, A., Ritchie, M., … Stetler, C. (2010). A critical synthesis of literature on the promoting action on research implementation in health services (PARIHS) framework. *Implementation Science*, *5*(1). https://doi.org/10.1186/1748-5908-5-82

Higuchi, K. S., Davies, B., & Ploeg, J. (2017). Sustaining guideline implementation: A multisite perspective on activities, challenges, and supports. *Journal of Clinical Nursing*, *26*(23–24), 4413–4424. https://doi.org/10.1111/jocn.13770

Hoskins, A. B. (2006). Occupational injuries,illnesses, and fatalities among nursing, psychiatric, and home health aides, 1995-2004. Retrieved from https://www.bls.gov/opub/mlr/cwc/occupational-injuries-illnesses-and-fatalities-among-nursing-psychiatric-and-home-health-aides-1995-2004.pdf

Huberman, M. (1994). Research utilization: The state of the art. *Knowledge and Policy*, *7*(4), 13–33. https://doi.org/10.1007/BF02696290

Hudson, R. B. (2003). Emerging crisis: The geriatric care workforce. *Public Policy & Aging Report*, *13*(2), 1–2. https://doi.org/10.1093/ppar/13.2.1

Humphreys, J., Hegney, D., Lipscombe, J., Gregory, G., & Chater, B. (2002). Whither rural health? Reviewing a decade of progress in rural health. *Australian Journal of Rural Health*, *10*(1), 2–14. https://doi.org/10.1046/j.1440-1584.2002.00435.x

Hunsberger, M., Baurmann, A., Blythe, J., & Crea, M. (2009). Sustaining the rural workforce: Nursing perspectives on worklife challenges. *The Journal of Rural Health*, *25*(17–25). https://doi.org/10.1111/j.1748-0361.2009.00194.x

Hunt, S., & Hunt, E. (2016). Barriers to practice of rural and remote nursing in Canada. *European Scientific Journal*, *12*(36), 56–69. https://doi.org/10.19044/esj.2016.v12n36p56

Hutchinson, A. M., & Johnston, L. (2004). Bridging the divide: A survey of nurses' opinions regarding barriers to, and facilitators of, research utilization in the practice setting. *Journal of Clinical Nursing*, *13*(3), 304–315. https://doi.org/10.1046/j.1365-2702.2003.00865.x

Ilkiw-Lavalle, O., Grenyer, B. F. S., & Graham, L. (2002). Does prior training and staff occupation influence knowledge acquisition from an aggression management training program? *International Journal of Mental Health Nursing*, *11*(4), 233–239. Retrieved from https://onlinelibrary.wiley.com/journal/14470349

Isaksson, U., Graneheim, U. H., Åström, S., & Karlsson, S. (2011). Physically violent behaviour in dementia care: Characteristics of residents and management of violent situations. *Aging & Mental Health*, *15*(5), 573–579. https://doi.org/10.1080/13607863.2011.556600

Jakobsen, R., & Sørlie, V. (2016). Ethical challenges: Trust and leadership in dementia care. *Nursing Ethics*, *23*(6), 636–645. https://doi.org/10.1177/0969733015580810

Janes, N., Fox, M., Lowe, M., McGilton, K., & Schindel Martin, L. (2009). Facilitating best practice in aged care: Exploring influential factors through critial incident technique. *International Journal of Older People Nursing*, *4*(3), 166–176. https://doi.org/10.1111/j.1748-3743.2009.00169.x

Johnson, K., Hays, C., Center, H., & Daley, C. (2004). Building capacity and sustainable prevention innovations: A sustainability planning model. *Evaluation and Program Planning*, *27*(2), 135–149. https://doi.org/10.1016/j.evalprogplan.2004.01.002

Jones, C., Moyle, W., & Stockwell-Smith, G. (2013). Caring for older people with dementia: An exploratory study of staff knowledge and perception of training in three Australian dementia care facilities. *Australasian Journal on Ageing*, *32*(1), 52–55. https://doi.org/10.1111/j.1741-6612.2012.00640.x

Kaasalainen, S., Ploeg, J., Donald, F., Coker, E., Brazil, K., Martin-Misener, R., … Hadjistavropoulos, T. (2015). Positioning clinical nurse specialists and nurse practitioners as change champions to implement a pain protocol in long-term care. *Pain Management Nursing*, *16*(2), 78–88. https://doi.org/10.1016/j.pmn.2014.04.002

Kavanagh, T., Watt-Watson, J., & Stevens, B. (2007). An examination of the factors enabling the successful implementation of evidence-based acute pain practices into pediatric nursing. *Children's Health Care*, *36*(3), 303–321. https://doi.org/10.1080/02739610701377970

Khalil, H. (2016). Knowledge translation and implementation science. *International Journal of Evidence-Based Healthcare*, *14*(2), 39–40. https://doi.org/10.1097/XEB.0000000000000086

Kitson, A., & Harvey, G. (2015). Getting started with facilitation: The Facilitator's role. In G. Harvey & A. Kitson (Eds.), *Implementing evidence-based practice in healthcare: A facilitation guide* (pp. 70–84). New York, NY: Routledge.

Kitson, A., Harvey, G., & McCormack, B. (1998). Enabling the implementation of evidence based practice: a conceptual framework. *Quality in Health Care*, *7*(3), 149–158. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/10185141

Kitson, A. L. (2009). The need for systems change: Reflections on knowledge translation and organizational change. *Journal of Advanced Nursing*, *65*(1), 217–228. https://doi.org/10.1111/j.1365-2648.2008.04864.x

Kitson, A. L., & Harvey, G. (2016). Methods to succeed in effective knowledge translation in clinical practice. *Journal of Nursing Scholarship*, *48*(3), 294–302. https://doi.org/10.1111/jnu.12206

Kitson, A. L., Rycroft-Malone, J., Harvey, G., McCormack, B., Seers, K., & Titchen, A. (2008). Evaluating the successful implementation of evidence into practice using the PARiHS framework: Theoretical and practical challenges. *Implementation Science*, *3*(1), 1. https://doi.org/10.1186/1748-5908-3-1

Kitwood, T. (1997). *Dementia reconsidered*. New York: Open University Press.

Kolanowski, A. M., & Garr, M. (1999). The relation of premorbid factors to aggressive physical behaviour in dementia. *Journal of Neuroscience Nursing*, *31*(5), 278–284. Retrieved from https://journals.lww.com/jnnonline/pages/default.aspx

Korniewicz, D. M. (2015). Understanding leadership, change, and the role of nurse practitioners in clinical practice settings. In D. M. Korniewicz (Ed.), *Nursing leadership and management: The advanced practice role* (pp. 15–30). Lancaster: DEStech Publications, Inc.

Kosteniuk, J. G., D'Arcy, C., Stewart, N., & Smith, B. (2006). Central and peripheral information source use among rural and remote Registered Nurses. *Journal of Advanced Nursing*, *55*(1), 100–114. https://doi.org/10.1111/j.1365-2648.2006.03879.x

LaMascus, A. M., Bernard, M. A., Barry, P., Salerno, J., & Weiss, J. (2005). Bridging the workforce gap for our aging society: How to increase and improve knowledge and training. Report of an expert panel. *Journal of the American Geriatrics Society*, *53*(2), 343–347. https://doi.org/10.1111/j.1532-5415.2005.53137.x

Lee, S. J., Altschul, I., & Mowbray, C. T. (2008). Using planned adaptation to implement evidence-based programs with new populations. *American Journal of Community Psychology*, *41*(3–4), 290–303. https://doi.org/10.1007/s10464-008-9160-5

Lennox, D. (2004). Is your staff ready for violent residents? Retrieved from https://www.iadvanceseniorcare.com/article/your-staff-ready-violent-residents

Li, J., & Porock, D. (2014). Resident outcomes of person-centered care in long-term care: A narrative review of interventional research. *International Journal of Nursing Studies*, *51*(10), 1395–1415. https://doi.org/10.1016/j.ijnurstu.2014.04.003

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage Publications.

Lipnicki, D. M., Sachdev, P. S., Crawford, J., Reppermund, S., Kochan, N. A., Trollor, J. N., … Brodaty, H. (2013). Risk factors for late-life cognitive decline and variation with age and sex in the Sydney memory and ageing study. *PLoS ONE*, *8*(6), e65841. https://doi.org/10.1371/journal.pone.0065841

Locock, L., Dopson, S., Chambers, D., & Gabbay, J. (2001). Understanding the role of opinion leaders in improving clinical effectiveness. *Social Science & Medicine*, *53*(6), 745–757. https://doi.org/10.1016/S0277-9536(00)00387-7

Loman, S. L., Rodriguez, B. J., & Horner, R. H. (2010). Sustainability of a targeted intervention package: First step to success in Oregon. *Journal of Emotional and Behavioral Disorders*, *18*(3), 178–191. https://doi.org/10.1177/1063426610362899

Lundgren, D., Ernsth-Bravell, M., & Kåreholt, I. (2016). Leadership and the psychosocial work environment in old age care. *International Journal of Older People Nursing*, *11*(1), 44–54. https://doi.org/10.1111/opn.12088

Lynch, B. M., McCance, T., McCormack, B., & Brown, D. (2018). The development of the person-centered situational leadership framework: Revealing the being of person-centeredness in nursing homes. *Journal of Clinical Nursing*, *27*(1–2), 427–440. https://doi.org/10.1111/jocn.13949

MacLeod, M., Stewart, N., Kulig, J., Anguish, P., Andrews, M. E., Banner, D., … Zimmer, L. (2017). Nurses who work in rural and remote communities in Canada: A national survey. *Human Resources for Health*, *15*(34). https://doi.org/10.1186/s12960-017-0209-0

Maher, L., Gustafson, D., & Evans, A. (2007). *Sustainability model and guide*. Retrieved from https://improvement.nhs.uk/resources/Sustainability-model-and-guide

Mancini, J. A., & Marek, L. I. (2004). Sustaining community-based programs for families: Conceptualization and measurement. *Family Relations*, *53*(4), 339–347. https://doi.org/10.1111/j.0197-6664.2004.00040.x

Marshall, C., & Rossman, G. B. (2011). *Designing qualitative research*. Los Angeles, CA: Sage Publications.

McCloskey, R. (2008). A guide to discourse analysis. *Nurse Researcher*, *16*(1), 24–44. https://doi.org/10.7748/nr2008.10.16.1.24.c6751

McCormack, B., Kitson, A., Harvey, G., Rycroft-Malone, J., Titchen, A., & Seers, K. (2002). Getting evidence into practice: The meaning of "context". *Journal of Advanced Nursing*, *38*(1), 94–104. Retrieved from https://onlinelibrary.wiley.com/journal/13652648

McCormack, B., Rycroft-Malone, J., DeCorby, K., Hutchinson, A. M., Bucknall, T., Kent, B., … Wilson, V. (2013). A realist review of interventions and strategies to promote evidence-informed healthcare: A focus on change agency. *Implementation Science*, *8*(1), 107. https://doi.org/10.1186/1748-5908-8-107

McDonald, S. (2005). Studying actions in context: A qualitative shadowing method for organizational research. *Qualitative Research*, *5*(4), 455–473. https://doi.org/10.1177/1468794105056923

McGillis Hall, L., McGilton, K. S., Krejci, J., Pringle, D., Johnston, E., Fairley, L., & Brown, M. (2005). Enhancing the quality of supportive supervisory behavior in long-term care facilities. *The Journal of Nursing Administration*, *35*(4), 181–187. Retrieved from https://journals.lww.com/jonajournal/pages/default.aspx

McGilton, K., McGilliis Hall, L., Boscart, V., & Brown, M. (2007). Effects of director of care support on job stress and job satisfaction among long-term care nurse supervisors. *Nursing Leadership, 20*(3), 52–66. https://doi.org/10.12927/cjnl.2007.19288

McGilton, K. S. (2003). Development and psychometric evaluation of supportive leadership scales. *The Canadian Journal of Nursing Research*, *35*(4), 72–86. Retrieved from https://us.sagepub.com/en-us/nam/canadian-journal-of-nursing-research/journal202552

McGilton, K. S. (2010). Development and psychometric testing of the supportive supervisory scale. *Journal of Nursing Scholarship*, *42*(2), 223–232. https://doi.org/10.1111/j.1547-5069.2009.01323.x

McGilton, K. S., Chu, C. H., Shaw, A. C., Wong, R., & Ploeg, J. (2016). Outcomes related to effective nurse supervision in long-term care homes: An integrative review. *Journal of Nursing Management*, *24*(8), 1007–1026. https://doi.org/10.1111/jonm.12419

McGilton, K. S., Bowers, B. J., Heath, H., Shannon, K., Dellefield, M., Prentice, D., … Mueller, C. A. (2016). Recommendations from the international consortium on professional nursing practice in long-term care homes. *Journal of the American Medical Directors Association, 17*, 99-103 https://doi.org/10.1016/j.jamda.2015.11.001

McKinney, S. H., Corazzini, K., Anderson, R. A., Sloane, R., & Castle, N. G. (2016). Nursing home director of nursing leadership style and director of nursing-sensitive survey deficiencies. *Health Care Management Review*, *41*(3), 224–232. https://doi.org/10.1097/HMR.0000000000000072

McMillan, K. (2014). Sustainability: An evolutionary concept analysis. Exploring nursing's role within the sustainability movement. *Journal of Advanced Nursing*, *70*(4), 756–767. https://doi.org/10.1111/jan.12250

Mekki, T. E., Øye, C., Kristensen, B., Dahl, H., Haaland, A., Nordin, K. A., … McCormack, B. (2017). The inter-play between facilitation and context in the promoting action on research implementation in health services framework: A qualitative exploratory implementation study embedded in a cluster randomized controlled trial to reduce restraint in nursing. *Journal of Advanced Nursing*, *73*(11), 2622–2632. https://doi.org/10.1111/jan.13340

Meit, M., Knudson, A., Gilbert, T., Tzy-Chyi Yu, A., Tanenbaum, E., Ormson, E., … NORC Walsh Center for Rural Health Analysis. (2014). *The 2014 update of the rural-urban chartbook*. Retrieved from http://www.ruralhealthresearch.org/.

Moazzami, B. (2015). *Strenghtening rural Canada: Fewer and older: Population and demographic crossroads in rural Saskatchewan.* Retrieved from http://strengtheningruralcanada.ca/file/Strengthening-Rural-Canada-Fewer-and-Older-Population-and-Demographic-Crossroads-in-Saskatchewan.pdf

Moore, J. E., Mascarenhas, A., Bain, J., & Straus, S. E. (2017). Developing a comprehensive definition of sustainability. *Implementation Science*, *12*(1), 110. https://doi.org/10.1186/s13012-017-0637-1

Morgan, D. G., Stewart, N. J., Crossley, M., D'Arcy, C., Biem, J., Kirk, A., & Forbes, D. (2005). Dementia care in rural and remote areas: The first year of a CIHR new emerging team. *The Canadian Journal of Nursing Research*, *37*(1), 177–182. Retrieved from https://us.sagepub.com/en-us/nam/canadian-journal-of-nursing-research/journal202552

Morgan, D., Innes, A., & Kosteniuk, J. (2011). Dementia care in rural and remote settings: A systematic review of formal or paid care. *Maturitas*, *68*(1), 17–33. https://doi.org/10.1016/j.maturitas.2010.09.008

Morgan, D., Stewart, N., Crossley, M., D'Arcy, C., Forbes, D., Normand, S., & Cammer, A. (2007). *Physical assault of special care aides: Let's take a look – A study report*. Retrieved from https://cchsa-ccssma.usask.ca/ruraldementiacare/publications/Physical Assault of SCAs Final Study Report May 15 2007.pdf

Morris, Z. S., Wooding, S., & Grant, J. (2011). The answer is 17 years, what is the question: Understanding time lags in translational research. *Journal of the Royal Society of Medicine*, *104*(12), 510–520. https://doi.org/10.1258/jrsm.2011.110180

Moyle, W., Hsu, M. C., & Vernooij-Dassen, M. (2010). Recommendations for staff education and training for older people with mental illness in long-term aged care. *International Psychogeritrics*, *22*(7), 1097–1106. https://doi.org/10.1017/S10416102100001754

Nakrem, S. (2015). Understanding organizational and cultural premises for quality of care in nursing homes: An ethnographic study. *BMC Health Services Research*, *15*(1), 508. https://doi.org/10.1186/s12913-015-1171-y

Needham, I., Abderhalden, C., Halfens, R. J. G., Dassen, T., Haug, H. J., & Fischer, J. E. (2005). The effect of a training course in aggression management on mental health nurses' perceptions of aggression: a cluster randomised controlled trial. *International Journal of Nursing Studies*, *42*(6), 649–655. https://doi.org/10.1016/j.ijnurstu.2004.10.003

Nieboer, A. P., & Strating, M. M. H. (2012). Innovative culture in long-term care settings. *Health Care Management Review*, *37*(2), 165–174. https://doi.org/10.1097/HMR.0b013e318222416b

Nilsen, P. (2015). Making sense of implementation theories, models and frameworks. *Implementation Science*, *10*(1), 53. https://doi.org/10.1186/s13012-015-0242-0

Norton, L., & Shields, S. (2006). *In pursuit of the sunbeam: A practical guide to transformation from institution to household*. United States: Action Pact, Inc.

Nutley, S., Walter, I., & Davies, H. T. O. (2003). From knowing to doing. *Evaluation*, *9*(2), 125–148. https://doi.org/10.1177/1356389003009002002

O'Loughlin, J., Renaud, L., Richard, L., Gomez, L. S., & Paradis, G. (1998). Correlates of the sustainability of community-based heart health promotion interventions. *Preventive Medicine*, *27*(5 Pt 1), 702–712. https://doi.org/10.1006/pmed.1998.0348

Olsen, I. T. (1998). Sustainability of health care: A framework for analysis. *Health Policy and Planning*, *13*(3), 287–295. Retrieved from https://academic.oup.com/heapol/

Olswang, L. B., & Prelock, P. A. (2015). Bridging the gap between research and practice: Implementation science. *Journal of Speech Language and Hearing Research*, *58*(6), S1818. https://doi.org/10.1044/2015_JSLHR-L-14-0305

Orellana, K., Manthorpe, J., & Moriarty, J. (2017). What do we know about care home managers? Findings of a scoping review. *Health & Social Care in the Community*, *25*(2), 366–377. https://doi.org/10.1111/hsc.12313

Øye, C., Mekki, T. E., Jacobsen, F. F., & Førland, O. (2016). Facilitating change from a distance - a story of success? A discussion on leaders' styles in facilitating change in four nursing homes in Norway. *Journal of Nursing Management*, *24*(6), 745–754. https://doi.org/10.1111/jonm.12378

Paine-Andrews, A., Fisher, J. L., Campuzano, M. K., Fawcett, S. B., & Berkley-Patton, J. (2000). *Promoting sustainability of community health initiatives: An Empirical Case Study*. Health Promotion Practice, 1(3), 248-258. Retrieved from https://journals.sagepub.com/home/hpp

Palinkas, L. A., Ell, K., Hansen, M., Cabassa, L., & Wells, A. (2010). Sustainability of collaborative care interventions in primary care settings. *Journal of Social Work*, *11*(1), 99–117. https://doi.org/10.1177/1468017310381310

Panazzola, P., & Leipert, B. (2013). Exploring mental health issues of rural senior women residing in southwestern Ontario, Canada: A secondary analysis photovoice study. *Rural and Remote Health* , *13*(2), 1–13. Retrieved from https://www.rrh.org.au/journal/article/2320

Penz, K., D'Arcy, C., Stewart, N., Kosteniuk, J., Morgan, D., & Smith, B. (2007). Barriers to participation in continuing education activities among rural and remote nurses. *Journal of Continuing Education in Nursing*, *38*(2), 58-66; quiz 67-8, 93. Retrieved from https://www.healio.com/nursing/journals/jcen77

Pickering, C. E. Z., Nurenberg, K., & Schiamberg, L. (2017). Recognizing and responding to the "toxic" work environment: Worker safety, patient safety, and abuse/neglect in nursing homes. *Qualitative Health Research*, *27*(12), 1870–1881. https://doi.org/10.1177/1049732317723889

P.I.E.C.E.S. Program (2013). P.I.E.C.E.S. – Putting the pieces together. Retrieved from http://pieceslearning.com/

Pitblado, R., Koren, I., Macleod, M., Place, J., Kulig, J., & Stewart, N. (2013). *Characteristics and distribution of the regulated nursing workforce in rural and small town Canada*. Retrieved from https://www.unbc.ca/sites/default/files/news/38209/rrn2-report-characteristics-rural-nurses-canada-2003-2010/en2014mar12-unbc_ndb_report_final_lr.pdf

Pizzacalla, A., Montemuro, M., Coker, E., Martin, L. S., Gillies, L., Robinson, K., … Gusciora, J. (2015). Gentle persuasive approaches: Introducing an educational program on an orthopedic unit for staff caring for patients with dementia and delirium. *Orthopaedic Nursing*, *34*(2), 101–107. https://doi.org/10.1097/NOR.0000000000000127

Pluye, P., Potvin, L., & Denis, J.-L. (2004). Making public health programs last: Conceptualizing sustainability. *Evaluation and Program Planning*, *27*(2), 121–133. https://doi.org/10.1016/J.EVALPROGPLAN.2004.01.001

Pluye, P., Potvin, L., Denis, J.-L., Pelletier, J., & Mannoni, C. (2005). Program sustainability begins with the first events. *Evaluation and Program Planning*, *28*(2), 123–137. https://doi.org/10.1016/J.EVALPROGPLAN.2004.10.003

Prentice, D., Boscart, V., McGilton, K. S., & Escrig, A. (2017). Factors influencing new RNs' supervisory performance in long-term care facilities. *Canadian Journal on Aging*, *36*(4), 463–471. https://doi.org/10.1017/S0714980817000411

Rabin, B., & Brownson, R. (2012). Developing the terminology for dissemination and implementation research. In R. C. Brownson, G. A. Colditz, & E. K. Proctor (Eds.), *Dissemination and implementation research in health: Translating science to practice* (pp. 23–51). New York, NY: Oxford University Press.

Rahman, S. (2015). *Living better with dementia*. Philadelphia, PA: Jessica Kingsley Publishers.

Rapaport, P., Livingston, G., Murray, J., Mulla, A., & Cooper, C. (2017). Systematic review of the effective components of psychsocial interventions delivered by care home staff to people with dementia. *British Medical Journal Open*, *7*. https://doi.org/10.1136/bmjopen-2016-014177

Ritchie, M. J., Parker, L. E., Edlund, C. N., & Kirchner, J. E. (2017). Using implementation facilitation to foster clinical practice quality and adherence to evidence in challenged settings: A qualitative study. *BMC Health Services Research*, *17*(1), 294. https://doi.org/10.1186/s12913-017-2217-0

Rokstad, A. M. M., Vatne, S., Engedal, K., & Selbaek, G. (2015). The role of leadership in the implementation of person-centered care using dementia care mapping: A study in three nursing homes. *Journal of Nursing Management*, *23*(1), 15–26. https://doi.org/10.1111/jonm.12072

Rycroft-Malone, J. (2004). The PARIHS framework--a framework for guiding the implementation of evidence-based practice. *Journal of Nursing Care Quality*, *19*(4), 297–304. Retrieved from https://journals.lww.com/jncqjournal/pages/default.aspx

Rycroft-Malone, J. (2010). Promoting action on research implementation in health services (PARIHS). In J. Rycroft-Malone & T. Bucknall (Eds.), *Models and frameworks for implementing evidence-based practice: Linking evidence to action* (pp. 109–136). West Sussex, UK: Wiley-Blackwell.

Rycroft-Malone, J., Kitson, A., Harvey, G., McCormack, B., Seers, K., Titchen, A., & Estabrooks, C. (2002). Ingredients for change: Revisiting a conceptual framework. *Quality & Safety in Health Care*, *11*(2), 174–180. https://doi.org/10.1136/QHC.11.2.174

Sapru, I. S., Cassidy, K., & Sibbald, S. L. (2014). Perceived barriers to accessing specialized medical care in rural communities of Ontario: A pilot study. *Western Undergraduate Research Journal: Health and Natural Sciences*, *5*(1). https://doi.org/10.5206/wurjhns.2011-12.1

Savaya, R., Spiro, S., & Elran-Barak, R. (2008). Sustainability of social programs: A comparative case study analysis. *American Journal of Evaluation*, *29*(4), 478–493. https://doi.org/10.1177/1098214008325126

Scheirer, M. A. (2005). Is sustainability possible? A review and commentary on empirical studies of program sustainability. *American Journal of Evaluation*, *26*(3), 320–347. https://doi.org/10.1177/1098214005278752

Scheirer, M. A. (2013). Linking sustainability research to intervention types. *American Journal of Public Health*, *103*(4), e73–e80. https://doi.org/10.2105/AJPH.2012.300976

Scheirer, M. A., & Dearing, J. W. (2011). An agenda for research on the sustainability of public health programs. *American Journal of Public Health*, *101*(11), 2059–2067. https://doi.org/10.2105/AJPH.2011.300193

Scheirer, M. A., Hartling, G., & Hagerman, D. (2008). Defining sustainability outcomes of health programs: Illustrations from an on-line survey. *Evaluation and Program Planning*, *31*(4), 335–346. https://doi.org/10.1016/j.evalprogplan.2008.08.004

Schindel Martin, L., & Dupuis, S., (2005). Gentle persuasive approaches curriculum development and pilot evaluation of an educational program to train long-term care front-line staff in the management of responsive behaviours of a more catastrophic nature associated with dementia final report. Retrieved from http://ageinc.s3.amazonaws.com/uploads/2017/01/GPA-Project-Final-Report-March-2005-rev-nov-1.pdf

Schindel Martin, L., Gillies, L., Coker, E., Pizzacalla, A., Montemuro, M., Suva, G., & McLelland, V. (2016). An education intervention to enhance staff self-efficacy to provide dementia care in an acute care hospital in Canada. *American Journal of Alzheimer's Disease & Other Dementias*, *31*(8), 664–677. https://doi.org/10.1177/1533317516668574

Schoeneman, K. (2010). *The language of culture change.* Retrieved from https://www.pioneernetwork.net/wp-content/uploads/2016/10/The-Language-of-Culture-Change.pdf

Scott, A., Ryan, A., James, I. A., & Mitchell, E. A. (2011a). Psychological trauma and fear for personal safety as a result of behaviours that challenge in dementia: The experiences of healthcare workers. *Dementia*, *10*(2), 257–269. https://doi.org/10.1177/1471301211407807

Scott, A., Ryan, A., James, I., & Mitchell, E. A. (2011b). Perceptions and implications of violence from care home residents with dementia: A review and commentary. *International Journal of Older People Nursing*, *6*(2), 110–122. https://doi.org/10.1111/j.1748-3743.2010.00226.x

Scott, J. (2000). A nursing leadership challenge: Managing the chronically ill in rural settings. *Nursing Administration Quarterly*, *24*(3), 21–32. Retrieved from http://journals.lww.com/naqjournal/pages/default.aspx

Selbæk, G., Engedal, K., & Bergh, S. (2013). The prevalence and course of neuropsychiatric symptoms in nursing home patients with dementia: A systematic review. *Journal of the American Medical Directors Association*, *14*(3), 161–169. https://doi.org/10.1016/j.jamda.2012.09.027

Shediac-Rizkallah, M. C., & Bone, L. R. (1998). Planning for the sustainability of community-based health programs: Conceptual frameworks and future directions for research, practice and policy. *Health Education Research*, *13*(1), 87–108. Retrieved from https://academic.oup.com/her/

Simmons, M. (2004). "Facilitation" of practice development: A concept analysis. *Practice Development in Health Care*, *3*(1), 36–52. https://doi.org/doi: 10.1002/pdh.121

Simmons, R., & Shiffman, J. (2007). *Scaling up health service delivery: From pilot innovations to policies and programmes*. (R. Simmons, P. Fajans, & L. Ghiron, Eds.). World Health Organization. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/43794/9789241563512_eng.pdf;jsessionid=13B872FDF633A093A4D6D772559F17CB?sequence=1

Skehan, J. (2015). Nursing leaders: Strategies for eradicating bullying in the workforce. *Nurse Leader*, *13*(2), 60–62. https://doi.org/10.1016/J.MNL.2014.07.015

Skinner, N., Hanlon, N., & Halseth, G. (2012). Health and social care issues in aging resource communities. In J. C. Kulig & A. M. Williams (Eds.), *Health in rural Canada* (pp. 462–480). Vancouver: UBCPress. Retrieved from www.ubcpress.ca

Snellgrove, S., Beck, C., Green, A., & McSweeney, J. C. (2015). Putting residents first: Strategies developed by CNAs to prevent and manage resident-to-resident violence in nursing homes. *The Gerontologist*, *55*(Suppl 1), S99–S107. https://doi.org/10.1093/geront/gnu161

Spector, A., Orrell, M., & Goyder, J. (2013). A systematic review of staff training interventions to reduce the behavioural and psychological symptoms of dementia. *Ageing Research Reviews*, *12*, 354–364. https://doi.org/10.1016/j.arr.2012.06.005

Spector, A., Revolta, C., & Orrell, M. (2016). The impact of staff training on staff outcomes in dementia care: A systematic review. *International Journal of Geriatric Psychiatry*, *31*(11), 1172–1187. https://doi.org/10.1002/gps.4488

Spetz, J., Skillman, S. M., & Andrilla, C. H. A. (2017). Nurse practitioner autonomy and satisfaction in rural settings. *Medical Care Research and Review*, *74*(2), 227–235. https://doi.org/10.1177/1077558716629584

Speziale, J., Black, E., Coatsworth-Puspoky, R., Ross, T., & O'Regan, T. (2009). Moving forward: Evaluating a curriculum for managing responsive behaviors in a geriatric psychiatry inpatient population. *The Gerontologist*, *49*(4), 570–576. https://doi.org/10.1093/geront/gnp069

Stake, R. (2006). *Multiple case study analysis*. New York, NY: Guilford Press.

Statistics Canada. (2016). *Census survey 2016: Population data for individuals over the age of 65 stratified by rural, urban, and sex in Canada*. Retrieved from Custom Profile

Statistics Canada. (2017a). *Age and sex, and type of dwelling: Key results from the 2016 census*. Retrieved from http://www.statcan.gc.ca/daily-quotidien/170503/dq170503a-eng.htm

Statistics Canada. (2017b). *Census of population*. *Statistics Canada*. Retrieved from https://www12.statcan.gc.ca/census-recensement/2016/ref/dict/geo049a-eng.cfm

Stetler, C. B., Damschroder, L. J., Helfrich, C. D., & Hagedorn, H. J. (2011). A Guide for applying a revised version of the PARIHS framework for implementation. *Implementation Science*, *6*(1), 99. https://doi.org/10.1186/1748-5908-6-99

Stetler, C. B., Legro, M. W., Rycroft-Malone, J., Bowman, C., Curran, G., Guihan, M., … Wallace, C. M. (2006). Role of "external facilitation" in implementation of research findings: A qualitative evaluation of facilitation experiences in the veterans health administration. *Implementation Science*, *1*(1), 23. https://doi.org/10.1186/1748-5908-1-23

Stetler, C. B., Ritchie, J. A., Rycroft-Malone, J., & Charns, M. P. (2014). Leadership for evidence-based practice: Strategic and functional behaviors for institutionalizing EBP. *Worldviews on Evidence-Based Nursing*, *11*(4), 219–226. https://doi.org/10.1111/wvn.12044

Stetler, C. B., Ritchie, J., Rycroft-Malone, J., Schultz, A., & Charns, M. (2007). Improving quality of care through routine, successful implementation of evidence-based practice at the bedside: An organizational case study protocol using the Pettigrew and Whipp model of strategic change. *Implementation Science*, *2*(1), 3. https://doi.org/10.1186/1748-5908-2-3

Stewart, H., Jameson, J. P., & Curtin, L. (2015). The relationship between stigma and self-reported willingness to use mental health services among rural and urban older adults. *Psychological Services*, *12*(2), 141–148. https://doi.org/10.1037/a0038651

Stewart, N., D'Arcy, C., Pitblado, R., Morgan, D., Forbes, D., Remus, G., … Macleod, M. (2005). A profile of registered nurses in rural and remote Canada. *The Canadian Journal of Nursing Research*, *37*(1), 122–145. Retrieved from http://cjnr.mcgill.ca

Stirman, S., Kimberly, J., Cook, N., Calloway, A., Castro, F., & Charns, M. (2012). The sustainability of new programs and innovations: A review of the empirical literature and recommendations for future research. *Implementation Science*, *7*(1), 17. https://doi.org/10.1186/1748-5908-7-17

Straus, S. E., Tetroe, J., & Graham, I. (2009). Defining knowledge translation. *CMAJ : Canadian Medical Association Journal*, *181*(3–4), 165–168. https://doi.org/10.1503/cmaj.081229

Talerico, K. A., & Evan, L. K. (2000). Making sense of aggressive/protective behaviour in persons with dementia. *Alzheimer's Care Quarterly*, *1*(4), 77–88. Retrieved from https://www.scimagojr.com/journalsearch.php?q=4700152282&tip=sid

Thompson, G. N., Estabrooks, C. A., & Degner, L. F. (2006). Clarifying the concepts in knowledge transfer: A literature review. *Journal of Advanced Nursing*, *53*(6), 691–701. https://doi.org/10.1111/j.1365-2648.2006.03775.x

Tong, M., Schwendimann, R., & Zúñiga, F. (2017). Mobbing among care workers in nursing homes: A cross-sectional secondary analysis of the Swiss Nursing Homes Human Resources Project. *International Journal of Nursing Studies*, *66*, 72–81. https://doi.org/10.1016/j.ijnurstu.2016.12.005

Trépanier, S.-G., Fernet, C., Austin, S., & Boudrias, V. (2016). Work environment antecedents of bullying: A review and integrative model applied to registered nurses. *International Journal of Nursing Studies*, *55*, 85–97. https://doi.org/10.1016/j.ijnurstu.2015.10.001

Tricco, A. C., Ashoor, H. M., Cardoso, R., MacDonald, H., Cogo, E., Kastner, M., … Straus, S. E. (2015). Sustainability of knowledge translation interventions in healthcare decision-making: A scoping review. *Implementation Science, 11*(1), 55. https://doi.org/10.1186/s13012-016-0421-7

Trochim, W. M. K. (1989). Outcome pattern matching and program theory. *Evaluation and Program Planning, 12*(4), 355–366. https://doi.org/10.1016/0149-7189(89)90052-9

Ullrich, P. M., Sahay, A., & Stetler, C. B. (2014). Use of implementation theory: A focus on PARIHS. *Worldviews on Evidence-Based Nursing, 11*(1), 26–34. https://doi.org/10.1111/wvn.12016

van Beek, A. P. A., & Gerritsen, D. L. (2010). The relationship between organizational culture of nursing staff and quality of care for residents with dementia: Questionnaire surveys and systematic observations in nursing homes. *International Journal of Nursing Studies, 47*(10), 1274–1282. https://doi.org/10.1016/j.ijnurstu.2010.02.010

van der Zijpp, T. J., Niessen, T., Eldh, A. C., Hawkes, C., McMullan, C., Mockford, C., … Seers, K. (2016). A bridge over turbulent waters: Illustrating the interaction between managerial leaders and facilitators when implementing research evidence. *Worldviews on Evidence-Based Nursing, 13*(1), 25–31. https://doi.org/10.1111/wvn.12138

Vogelsmeier, A., & Scott-Cawiezell, J. (2011). Achieving quality improvement in the nursing home. *Journal of Nursing Care Quality, 26*(3), 236–242. https://doi.org/10.1097/NCQ.0b013e31820e15c0

Wallin, L., Boström, A.-M., Wikblad, K., & Ewald, U. (2003). Sustainability in changing clinical practice promotes evidence-based nursing care. *Journal of Advanced Nursing, 41*(5), 509–518. Retrieved from https://onlinelibrary.wiley.com/journal/13652648

Wang, S., Hayes, L., & O'brien-Pallas, L. (2008). *A review and evaluation of workplace violence prevention programs in the health sector final report*. Retrieved from http://www.mtpinnacle.com/pdfs/Rev-Work-violence-MOHLTC-2008.pdf

Waterman, H., Boaden, R., Burey, L., Howells, B., Harvey, G., Humphreys, J., … Spence, M. (2015). Facilitating large-scale implementation of evidence based health care: Insider accounts from a co-operative inquiry. *BMC Health Services Research, 15*(1), 60. https://doi.org/10.1186/s12913-015-0722-6

Weinhold, I., & Gurtner, S. (2014). Understanding shortages of sufficient health care in rural areas. *Health Policy, 118*(2), 201–214. https://doi.org/10.1016/j.healthpol.2014.07.018

Wingens, M. (1990). Toward a general utilization theory. *Knowledge, 12*(1), 27–42. https://doi.org/10.1177/107554709001200103

Winters, C. A., Lee, H. J., Besel, J., Strand, A., Echeverri, R., Jorgensen, K. P., & Dea, J. E. (2007). Access to and use of research by rural nurses. *Rural and Remote Health, 7*(3), 758. Retrieved from https://www.rrh.org.au/

WorkSafe BC. (2013). *Policies for workers compensation act*. Retrieved from https://www.worksafebc.com/en/law-policy/occupational-health-safety/searchable-ohs-regulation/ohs-policies/policies-for-the-workers-compensation-act#SectionNumber:D3-115-2.

World Health Organization. (2010). *Increasing access to health workers in remote and rural areas through retention*. Retrieved from http://www.searo.who.int/nepal/mediacentre/2010_increasing_access_to_health_workers_in_remote_and_rural_areas.pdf

World Health Organization. (2017). 10 facts on dementia. Retrieved from https://www.who.int/features/factfiles/dementia/en/

Yin, R. (1984). *Case study research: Design and methods*. Beverly Hills, CA: Sage Publications.

Yin, R. (2009). *Case study research: Design and methods*. Los Angeles, CA: Sage Publications.

Yin, R. (2014). *Case study research: Design and methods*. Los Angeles, CA: Sage Publications.

Zwijsen, S. A., Kabboord, A., Eefsting, J. A., Hertogh, C. M. P. M., Pot, A. M., Gerritsen, D. L., & Smalbrugge, M. (2014). Nurses in distress? An explorative study into the relation between distress and individual neuropsychiatric symptoms of people with dementia in nursing homes. *International Journal of Geriatric Psychiatry*, *29*(4), 384–391. https://doi.org/10.1002/gps.4014

Appendix A

Poster for Focus Group

Attention all Special Care Aides

You Are Invited to Participate in a Focus Group about the Gentle Persuasive Approaches Program

This focus group is being held to find out about your experience with using the GPA skills within your daily practice. This information is being used to discover what factors allow a training program to succeed in rural long-term care homes.

Date:

Place:

Time:

A $5.00 gift certificate to Tim Horton's will be provided to those who attend the focus group.

Appendix B

Poster for Semi-Structured Interviews

Attention Staff

You Are Invited to Participate in a Semi-Structured Interviews about the Gentle Persuasive Approaches Program

The semi-structured interviews are being held to find out about your experience with using the GPA skills within your daily practice. This information is being used to discover what factors allow a training program to succeed in rural long-term care homes.

Date:

Place:

Time:

A $5.00 gift certificate to Tim Horton's will be provided to those who attend the semi-structured interviews.

Appendix C

UNIVERSITY OF SASKATCHEWAN

Consent to Participate in a Research Study

Title: Understanding the Role of Facilitation in the Implementation and Sustainability of an Educational Program in Rural Long-Term Care Homes

Investigator: Tracy Danylyshen-Laycock, Doctoral Student, College of Medicine, University of Saskatchewan

Supervisor: Dr. Debra Morgan, CIHR-SHRF Applied Chair in Health Sciences & Policy Research Chair, Rural Health Delivery, Canadian Centre for Health and Safety in Agriculture, University of Saskatchewan

Purpose and Objectives of the Study

You are invited to take part in this research study because you have had the opportunity to take the Gentle Persuasive Approaches Training within your long term-care home. This study is being done because there is little information available on the factors that affect whether or not staff in long-term care homes use the skills that have been taught to them in a training program. Previous research has shown that facilitation plays an important role in whether or not a program is successful within the health care system. This study will try to find out how and in what ways facilitation affects whether or not staff use the skills taught to them in an educational program (GPA program) and what type of facilitation skills are required to improve the chances of staff successfully implementing them in their daily practice. This study will also try to find out whether or not there are other staff members (beyond the GPA Coaches) who help to implement the GPA program within long-term care homes.

Benefits of Participating in this Study

If you choose to participate in this study there may not be direct benefits to you. However, it is hoped that the information gained from this study can be used in the future to help long-term care homes find ways to effectively implement and sustain educational training programs.

Procedures

This study involves your participation in a short 15-30 minute interview or a 30-60 minute focus group to talk about your experiences related to your ability to implement the information from the GPA program and your thoughts related to the facilitation of the program within your long-term care home. You may refuse to answer any question that you are uncomfortable with. For questions that you may find upsetting (i.e., angry, or conflicted) you may contact the Employee/Family Assistance Program.

Possible Risks and Discomforts
There are no risks or discomforts associated with this study.

Participation
Your participation is voluntary. It is up to you to decide whether or not you wish to take part. If you decide to participate, you are still free to withdraw at any time and without giving any reasons for your decision. If you do not wish to participate, your employment will not be affected. If you choose to enter the study and then decide to withdraw at a later time, all data about you during your enrolment will be shredded and not included in the analysis for the study.

Anonymity and Confidentiality
All participants who agree to participate in this study will remain anonymous. The Consent Forms will be stored separately from the interview and/or focus group data so that it will not be possible to associate a name with any given set of responses. Your study records will be kept for five years in a locked filing cabinet under the supervision of Dr. Debra Morgan at the University of Saskatchewan. When the data is no longer required, it will then be appropriately destroyed.
The researcher will undertake to safeguard the confidentiality of the discussions within the focus group, but cannot guarantee that other members of the group will do so. Please respect the confidentiality of the other members of the group by not disclosing the contents of this discussion outside the group, and be aware that others may not respect your confidentiality.

Use of Collected Information
The information collected during this research study will be analyzed and the results will be published in a scientific journal and presented at international conferences. You will not be identified within this study as your data will be reported anonymously in a summarized form. You will be informed if any new information that may affect your decision to participate in this study becomes available.

Reimbursement
You will be provided a $5.00 dollar gift certificate from Tim Horton's to cover your time. If you decide to withdraw early from the study you will still be entitled to the $5.00 Tim Horton's gift certificate.

Ethics Approval

This research study has been reviewed and approved by the University of Saskatchewan Behavioural Research Ethics Board on October 11, 2011.

UNIVERSITY OF SASKATCHEWAN

Consent to Participate

- ○ I have read (or someone has read to me) and understood the description provided.
- ○ I have had an opportunity to ask question and my questions have been answered.
- ○ I consent to participate in the research project, understanding that I may withdraw my consent at any time.
- ○ I have received a copy of the Consent Form.

_____	_____
(Name of Participant)	(Date)
_____	_____
(Signature of Participant)	(Signature of Researcher)

Oral Consent

- ○ I read and explained this Consent Form to the participant before receiving the participant's consent, and the participant had knowledge of its contents and appeared to understand it.

_____
(Date)

_____
(Signature of Researcher)

Who Do I Contact if I Have Questions About the Study?

If you have any questions or desire further information about this study before or during participation, you can contact Tracy Danylyshen-Laycock at (306) 655-2518.

If you have any concerns about your rights as a research subject and/or your experiences while participating in the study, contact the University of Saskatchewan Research Ethics Board at (306) 966-2084.

Appendix D

Interview Guides Semi-Structured Interviews and Focus Groups

Interview Guide for Formal Leaders	Interview Guide for GPA Coaches
1. Tell me how the GPA program is being used by staff in your LTC home. 2. What was the role of the GPA Coaches in the implementation of the GPA program besides providing the actual 7.5 hour training program to staff? 3. Did the GPA Coaches provide any coaching or mentoring to staff in relation to using the skills and interventions taught in the GPA program? How did they do this? 4. Were there other individuals within your staff that advocated or championed this program to other staff within the LTC home? What did these individuals do to help implement the GPA program in your home? 5. Were there staff members who negatively impacted the implementation and sustainability of the GPA program? 6. What did you do in your leadership role to help implement and sustain the GPA program? 7. Do you feel the GPA program has been sustained in your home? 8. How you do you know whether this program is sustained in your home? 9. What will you do as a leader to sustain the GPA program in your home? 10. What factors have contributed to the success or failure of the implementation and sustainability of the GPA program?	1. Tell me how the GPA program is being used by staff in your LTC home. 2. What role do you play as a GPA Coach beyond providing the actual GPA training for staff? 3. What skills did you, as the GPA Coach, use to help the staff utilize the skills and interventions taught in the GPA training? 4. How were you able to use your expertise as a GPA Coach when you were working a shift with staff from your LTC home? 5. What additional skills could you have benefitted from to have better enabled you to be a GPA Coach both in the training sessions and in your daily practice? 6. What support would you have benefitted from with respect to the Master Coaches to have enabled you as a GPA Coach? 7. Were there other staff members who helped the GPA program to be successful? What did they do to make is a success? What skills did they use to make it successful? 8. Were there staff members who negatively impacted the implementation and sustainability of the GPA program? 9. Do you feel the GPA program has been sustained in your home? 10. How do you know whether this program is sustained in your home? 11. What is the role of your formal leadership in the success of the GPA program? 12. What factors have contributed to the success of failure of implementation and sustainability of the GPA program?

Interview guide for Nurses	Interview guide for Focus Groups/Nursing Aides and Staff in All Remaining Departments*
1. Tell me how the GPA program is being used by staff in your LTC home. 2. What was the role of the GPA Coaches in the implementation of the GPA program besides providing the actual 7.5 hour training program to staff? 3. Did the GPA Coaches provide any coaching or mentoring to staff in relation to using the skills and interventions taught in the GPA program? 4. Were there any other individuals within you staff who advocated or championed this program to other staff within your care home? What did these individuals do to help implement the GPA program in your home? 5. Were there staff members who negatively impacted the implementation and sustainability of the GPA program? 6. What did you do in your role as a nurse to help implement and sustain the GPA program in your home? 7. Do you feel the GPA program has been sustained in your home? 8. How do you know whether this program is sustained in within your home? 9. What factors contributed to the success or failure of the implementation and sustainability of this program? 10. What is the role of your formal leadership in the success of the GPA program? 11. To what extent do you think nurses play a role in sustainability of the GPA program?	1. Tell me how the GPA program is being used by staff in your LTC home. 2. How were you supported in your daily practice by the GPA Coaches in using the skills and interventions taught in the GPA Program? What did the Coaches do? 3. Were there other staff members who evolved as someone who helped make the program successful? 4. If so, what did these individuals do to help implement the GPA program in your home? 5. What supports do you need to make the skills taught in the GPA program a part of your daily practice? 6. Do you feel the GPA program has been sustained in your home? 7. How do you know whether this program is sustained in within your home? 8. What factors contributed to the success or failure of the GPA program in your home? 9. What can you do in your role as a staff member to help implement and sustain the GPA program in your home? 10. What is the role of leadership in implementing and supporting the ongoing use of the GPA program in your home?

Note: The Interview Guide for the Focus Groups was used in the Prospective Study to interview NAs and staff from all other departments excluding Formal Leaders, GPA Coaches, Nurses

Appendix E

Person-Centered Care Skills

Old Culture Versus the New Culture in Long-Term Care

Old Culture

- Residents with dementia were treated as non-persons
- Residents with dementia were discounted as human beings because of memory and thinking problems
- Staff are preoccupied with what the person with dementia cannot do
- If you cannot think and reason, you are not a person
- Staff infantalizing the resident (treating an adult like a baby)
- Staff labelling residents (using a term as the main way to describe or relate to a person)
- Staff outpacing the residents (providing information, choices, and activities) at a pace too fast for someone to follow
- Staff imposing on residents with dementia (forcing a person to do something that over-rides his/her desires of denying the possibility of choice
- Staff ignore the resident with dementia (carrying on a conversation or an action in the presences of someone as if he/she was not there)

New Culture

- The feelings of a person with dementia should be seriously considered
- The person with dementia has a unique history
- The person with dementia has significant others and families
- The person with dementia has the need for a supportive environment
- People with dementia are capable of relationships of deep meaning and can connect with other persons
- Residents with dementia are humans of great value and purpose
- Residents with dementia have many remaining strengths and abilities (knowing what the resident is still capable of doing)
- Staff understand the person behind the illness
- Staff do not deliberately/unwittingly ignore the feelings of the person with dementia
- Staff know and acknowledge the values, beliefs, dreams, hopes and desires of the residents
- Staff are honouring and preserving the values, beliefs, dreams, hopes and desires of the residents
- Staff respect the resident's basic rights of privacy and dignity
- Staff know the likes and dislikes of the residents they provide care to
- Staff value all human lives regardless of age or cognitive ability
- Staff use an individualized approach that respects uniqueness

New Culture (continued)

- Staff understand the world from the perspective of the person with dementia
- Residents are provided a social environment that supports psychological needs
- Staff validate the resident with dementia (supporting the emotions and feelings the person is experiencing)
- Staff collaborate with the resident with dementia (working together with the person to enhance his/her abilities and encourage his/her control and choice)
- Staff facilitate (accommodating the person's disabilities to enable her/him to do a task or activity)
- Staff play and celebrate with residents with dementia (encourage spontaneity, self-expression, joyfulness and celebration just for fun)
- Staff assist the resident with dementia to relax (helping the person to relax and feel comfortable without making any intellectual demands)
- Staff learn what makes a person with dementia happy and provide it
- Staff concentrate on the person, not the task
- The residents need to share, to love and to give
- The residents need to feel competent
- Residents need to have a sense of belonging
- Residents need to be useful and successful
- Residents need to feel hopeful
- Residents with dementia have an ultimate right to express their feelings
- If we acknowledge those feelings, it may help to relieve stress and reduce the likelihood that the person will express anger or frustration

Alzheimer's Disease Bill of Rights (Bell and Troxel, 1994)

Residents have a right to:

- Be informed of their diagnosis
- To have appropriate, ongoing medical care
- To be productive in work and play as long as possible
- To be treated like an adult, not a child
- To have expressed feelings taken seriously
- To be free from psychotropic medications if at all possible
- To live in a safe, structures and predictable environment
- To enjoy meaningful activities to fill each day
- To be out of doors on a regular basis
- To have physical contact including hugging, caressing, and hand-holding when appropriate and with permission
- To be with persons who know one's life story, including cultural/religious traditions
- To be cared for by individuals well-trained in dementia care

Appendix F

GPA Skills from Modules One through Four

Staff understand that:

- All behaviour has meaning
- Behaviour is a means of communication
- As care providers they must be the ones to interpret this communication and discover its meaning
- They are the ones who need to identify the unmet needs and the triggers behind the behaviour (e.g., pain, grief, anxiety, noise)

Communication

1. Staff use the "Stop and GO" approach when providing care to residents.
2. Staff minimize distractions.
3. Staff speak slowly and clearly in a soft and calm tone.
4. Staff use simple language with familiar words.
5. Staff avoid arguing and confronting residents.
6. Staff visually demonstrate what they are saying.
7. Staff repeat what they are saying.
8. Staff validate and respect resident's feelings in whatever time or place is real to the resident.
    a. Staff don't dismiss the resident
    b. Staff don't negate
    c. Staff don't ignore the resident
    d. Staff use distraction and redirection
9. Staff have an attitude of unconditional positive regard despite the level of behaviour displayed by the resident.
10. Staff are quiet, positive, helpful, kind and friendly.
11. Staff consider their tone, volume, and pace of their voice.
12. Staff portray body positions and facial expressions to convey a positive message.
13. Staff minimize distractions and noise.
14. Staff approach from the side.
15. Staff designate one person to communicate during pairs care.
16. Staff make genuine eye contact (cultural considerations).
17. Staff always introduce themselves to the resident.
18. Staff use the person's preferred name.
19. Staff stay calm and patient.
20. Staff connect with the resident's past.
21. Staff avoid arguing, confronting and quizzing the resident.
22. Staff use humour, music, rhythm and pets.

23. Staff learn how to connect with the resident with dementia and follow through with it.
24. Staff pass on their successes on to others (proper documentation of such).

Verbal and Environnemental De-escalation Techniques

1. Staff acquire resident's attention with eye contact.
2. Staff remove the audience instead of the resident if there is a responsive event.
3. Staff call for assistance when necessary.
4. Staff find someone familiar to the resident to help de-escalate them.
5. Staff scan the surroundings and eliminate any potential triggers.
6. Staff always use a quiet, calm manner and be aware of your body language/stance.
7. Staff don't over react to a verbally/physically protective behaviour.
8. Staff know when they have been asked to "stop" by the resident with dementia.
9. Staff use the "Stop and Go" technique when they have asked by the resident to stop.
10. Staff provide the resident undivided attention and support from a distance.
11. Staff give the resident space and much control as possible.
12. Staff use physical interventions as the last resort.
13. Staff are able to demonstrate the suitable techniques in response to responsive behaviours (i.e., biting, hitting, grabbing).
14. Staff are able to use the gentle re-direction techniques to bring a resident away from an unsafe situation or altercation with another person.

Support

1. Staff offer continued support to the resident after a responsive event.
2. Staff help the resident express their feelings after a responsive event.
3. Staff help the resident give voice to their emotions after a responsive event.
4. Staff acknowledge the feelings and emotions of the residents after a responsive event.
5. Staff ensure a calm environment for the resident after a responsive event.
6. Staff divert the resident with food, drink, quiet conversations after a responsive event.

Follow up after a responsive event

1. Staff ensure that no one involved in the responsive event has been injured.
2. Staff inform supervisors (or responsible person) if someone has been injured after a responsive event.
3. Staff discuss ways to inform the family after a responsive event.
4. Staff look for treatable causes (infection, pain, delirium) as a trigger for the responsive event.
5. Staff evaluate how they responded as a team to the responsive event.
6. Staff offer support to the team members who have been involved in a responsive event.
7. Staff engage with honest communication about the behaviour with family members.

Appendix G

Facilitation Strategies

Planning for Change	Monitoring Implementation
Increasing Awareness -Highlighting need for practice change -Selecting an area for change identified by staff -Stimulating critical inquiry -Assisting with performing a formal audit -Interpreting baseline data and provide feedback -Emphasizing resident outcomes as a reason for change	Problem-Solving -Making changes to the developed plan as required -Networking Effective Communication -Providing regular communication -Keeping group members informed
Developing a Plan -Assisting with developing an action plan -Helping identify and determine solutions to address potential barriers to practice change	Providing Support -Mentoring and role modelling -Maintaining momentum and enthusiasm -Acknowledging ideas and efforts -Providing ongoing support and feedback -Providing advice/skills training
Leading and Managing Change	**Leading and Managing Change**
Knowledge and Data Management -Conducting and summarizing literature searches -Interpreting research -Providing resources/tools for change Recognizing Importance of Context -Creating environment for change -Building processes for staff to overcome barriers -Creating local ownership for change -Adapting evidence to fit local context -Addressing organizational systems -Adapting facilitation to context Project Management -Identifying a leader/advocates for change -Establishing roles/delegates responsibility	Fostering Team Building -Relationship building and empowering staff -Creating effective teams -Enabling individual/group development -Ensuring participation/shared decision making -Helping to overcome resistance to change Administrative/Project Specific Support -Organizing, leading/participating in meetings -Gathering information and assembling reports
Evaluating Change	
-Performing/assisting with evaluation -Linking evidence implementation to resident outcomes -Acknowledging success and achievements	

Appendix H

Leadership Strategies

Flatten hierarchical structures	Evaluating program sustainability
Provide supervision to staff	Give specific feedback to staff
Utilize active listening skills	Communicate positively with staff
Find ways to overcome obstacles	Recruit champions/champions
Manage political dynamics	Encourage staff to use research findings
Create conducive learning environments	Support staff in difficult situations
Influence change within the organization	Provide coaching and mentoring to staff
Establish positive relationships with staff	Reflect upon practice issues
Recognize needs and values of staff	Recognize and value different points of view
Be available to staff	Keep staff aware of changes in the workplace
Respect uniqueness of staff and residents	Help staff with daily tasks
Collaborate with staff	Praise and recognize staff effort
Build trust within staff members	Express gratitude